restored retroactively to the pay period in which the disappearance occurred.

### § 880.304 FEGLI coverage.

(a) FEGLI premiums will not be collected during periods when an annuitant is a missing annuitant.

(b)(1) If the annuity of a missing annuitant is restored under § 880.204(a), OPM will deduct the amount of FEGLI premiums attributable to the period when the annuitant was a missing annuitant from any adjustment payment due the annuitant under § 880.204(a).

(2) If a missing annuitant is determined to be dead under § 880.205, FEGLI premiums and benefits will be computed using the date of death established under § 880.206(a).

# PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

## Subpart A—Administration and General Provisions



## Subpart B—Health Benefits Plans



## Subpart C—Enrollment



## Subpart D—Temporary Extension of Coverage and Conversion



## Subpart E—Contributions and Withholdings



## Subpart F—Transfers From Retired Federal Employees Health Benefits Program



## Subpart G [Reserved]

## Subpart H—Benefits for Former Spouses



## Subpart I—Limit on Inpatient Hospital Charges, Physician Charges, and FEHB Benefit Payments

## Subpart J—Administrative Sanctions Imposed Against Health Care Providers

REINSTATEMENT



CIVIL MONETARY PENALTIES AND FINANCIAL ASSESSMENTS



## Subpart K—Temporary Continuation of Coverage



## Subpart L—Benefits for United States Hostages in Iraq and Kuwait and United States Hostages Captured in Lebanon



## Subpart M—Department of Defense Federal Employees Health Benefits Program Demonstration Project



## Subpart N—Federal Employees Health Benefits For Employees of Certain Indian Tribal Employers

AUTHORITY: 5 U.S.C. 8913; Sec. 890.301 also issued under sec. 311 of Pub. L. 111–03, 123 Stat. 64; Sec. 890.111 also issued under section 1622(b) of Pub. L. 104–106, 110 Stat. 521; Sec. 890.112 also issued under section 1 of Pub. L. 110–279, 122 Stat. 2604; 5 U.S.C. 8913; Sec. 890.803 also issued under 50 U.S.C. 403p, 22 U.S.C. 4069c and 4069c–1; subpart L also issued under sec. 599C of Pub. L. 101–513, 104 Stat. 2064, as amended; Sec. 890.102 also issued under sections 11202(f), 11232(e), 11246(b) and (c) of Pub. L. 105–33, 111 Stat. 251; and section 721 of Pub. L. 105–261, 112 Stat. 2061; Pub. L. 111–148, as amended by Pub. L. 111–152.

SOURCE: 33 FR 12510, Sept. 4, 1968, unless otherwise noted.

## Subpart A—Administration and General Provisions

### § 890.101 Definitions; time computations.

(a) In this part, the terms *annuitant*, *carrier*, *employee*, *employee organization*, *former spouse*, *health benefits plan*, *member of family*, and *service*, have the meanings set forth in section 8901 of title 5, United States Code, and supplement the following definitions:

*Appropriate request* means a properly completed health benefits registration form or an alternative method acceptable to both the employing office and OPM. Alternative methods must be capable of transmitting to the health benefits plans the information they require before accepting an enrollment, change of enrollment, or cancellation. Electronic signatures, including the use of Personal Identification Numbers (PIN), have the same validity as a written signature.

*Basic employee death benefit* has the meaning set out at § 843.102. Survivors receiving this benefit are deemed to be ''annuitants'' for purposes of this chapter.

*Cancel* means to submit to the employing office an appropriate request electing not to be enrolled by an enrollee who is eligible to continue enrollment.

*Change the enrollment* means to submit to the employing office an appropriate request electing a change of enrollment to a different plan or option, or to a different type of coverage (self only, self plus one, or self and family).

*Claim* means a request for (i) payment of a health-related bill; or (ii) provision of a health-related service or supply.

*Compensation* means compensation under subchapter I of chapter 81 of title 5, United States Code, which is payable because of a job-related injury or disease.

*Compensationer* means an employee or former employee who is entitled to compensation and whom the Department of Labor determines is unable to return to duty. A compensationer is also an annuitant for purposes of chapter 89 of title 5, United States Code.

*Congressional staff member* means an individual who is a full-time or part-time employee employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.

*Covered individual* means an enrollee or a covered family member.

*Covered family member* means a member of the family of an enrollee with a self plus one or self and family enrollment who meets the requirements of §§ 890.302, 890.804, or 890.1106(a), as appropriate to the type of enrollee.

*Decrease enrollment type* means a change in enrollment from self and family to self plus one or to self only or a change from self plus one to self only.

*Election not to enroll* means to submit to the employing office an appropriate request electing not to be enrolled by an employee who is eligible to enroll.

*Eligible* means eligible under the law and this part to be enrolled.

*Employing office* means the office of an agency to which jurisdiction and responsibility for health benefits actions for an employee, an annuitant, a former spouse eligible for continued coverage under subpart H of this part, or an individual eligible for temporary continuation of coverage under subpart K of this part, have been delegated.

(1) For an enrolled annuitant (including survivor annuitant, former spouse annuitant, and surviving spouses receiving a basic employee death benefit

under 5 U.S.C. 8442(b)(1)(A)) who is not also an eligible employee, *employing office* is the office which has the authority to approve payment of annuity, basic employee death benefit, or workers' compensation for the annuitant concerned.

(2) For a former spouse of an annuitant whose marriage dissolved after the employee's retirement and who has entitlement to receive future annuity payments under sections 8341(h), 8345(j), 8445, or 8467 of title 5, United States Code, *employing office* is the office that has the authority to approve payment of annuity for the annuitant or former spouse concerned.

(3) For a former spouse of a current employee, and a former spouse of an annuitant or separated employee having title to a deferred annuity or to an immediate annuity under 5 U.S.C. 8412(g), whose marriage dissolved during the employee's Federal service, *employing office* is the agency that employed the employee or annuitant at the time the marriage was dissolved.

(4) For a surviving spouse in receipt of a basic employee death benefit under 5 U.S.C. 8442(b)(1)(A) who is not also an eligible employee, the *employing office* is the retirement system which has authority to approve the basic employee death benefit.

(5) For a former spouse of an employee or former employee of the Central Intelligence Agency (CIA) whose marriage was dissolved before May 7, 1985, and who meets the requirements under §890.803(a)(3)(iv), the *employing office* is the CIA.

(6) For a former spouse of an employee or former employee of the Foreign Service whose marriage was dissolved before May 7, 1985, and who meets the requirements under §890.803(a)(3)(v) of this part, the *employing office* is the Department of State.

(7) [Reserved]

(8) For a former spouse of an employee who separated from service after qualifying for an immediate annuity under 5 U.S.C. 8412(g), whose marriage dissolves after the employee separated from service but before the date the separated employee's annuity commences, and who is entitled to continued coverage under subpart H of this part, *employing office* is the office that has the authority to approve payment of annuity for the annuitant or former spouse concerned.

*Enroll* means to submit to the employing office an appropriate request electing to be enrolled in a health benefits plan.

*Enrolled* means an appropriate request has been accepted by the employing office and the enrollment in a health benefits plan approved by OPM under this part has not been terminated or cancelled.

*Enrollee* means the individual in whose name the enrollment is carried. The term includes employees, annuitants, former employees, former spouses, or children who are enrolled after completing an appropriate request under the provisions of §§890.301, 890.306, 890.601, 890.803, or 890.1103 or have continued an enrollment as an annuitant or survivor annuitant under 5 U.S.C. 8905(b) or §890.303.

*Foster child* means a child who:

(1) Lives with an employee, former employee, or annuitant or with a child enrolled under §890.1103(a)(2) in a regular parent-child relationship and

(2) Is expected to be raised to adulthood by the enrollee.

*Immediate annuity* means an annuity which begins to accrue not later than 1 month after the date enrollment under a health benefits plan would cease for an employee or member of family if he or she were not entitled to continue enrollment as an annuitant. Notwithstanding the foregoing, an annuity which commences on the birth of the posthumous child of an employee or annuitant is an immediate annuity. For an individual who separates from service upon meeting the requirements for an annuity under §842.204(a)(1) of this chapter, immediate annuity includes an annuity for which the commencing date is postponed under §842.204(c). For phased retirees, as defined in 5 U.S.C. 8336a and 8412a, a composite retirement annuity is an immediate annuity.

*Increase enrollment type* means a change in enrollment from self only to self plus one or to self and family or a change from self plus one to self and family.

*Letter of credit* is defined in 48 CFR 1602.170–10.

*Member of Congress* means a member of the Senate or of the House of Representatives, a Delegate to the House of Representatives, and the Resident Commissioner of Puerto Rico.

*Option* means a level of benefits. It does not include distinctions as to whether the members of the family are covered.

*OWCP* means the Office of Workers' Compensation Programs, U.S. Department of Labor, which administers subchapter I of chapter 81 of title 5, United States Code.

*Pay period* means the biweekly pay period established pursuant to section 5504 of title 5, United States Code, for the employees to whom that section applies and the regular pay period for employees not covered by that section. *Pay period,* as it relates to a former spouse or annuitant who is not actively receiving an annuity, including surviving spouses receiving a basic employee death benefit, and enrollees temporarily continuing coverage under subpart K of this part, means any regular pay period for employees of the agency to which jurisdiction and responsibility for health benefits actions for the enrollee have been delegated as provided under the definition of ''employing office'' in this section. *Pay period* for annuitants in active receipt of annuity means the period for which a single installment of annuity is customarily paid.

*Reconsideration* means the final level of administrative review of an employing office's initial decision to determine if the employing office correctly applied the law and regulations.

*Reimbursement* means a carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

*Self and family enrollment* means an enrollment that covers the enrollee and all eligible family members.

*Self only enrollment* means an enrollment that covers only the enrollee.

*Self plus one enrollment* means an enrollment that covers the enrollee and one eligible family member.

*SHOP* has the meaning given in 45 CFR 155.20.

*Subrogation* means a carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

*Switch a covered family member* means, under a self plus one enrollment, to terminate or cancel the enrollment of the designated covered family member and designate another eligible family member for coverage.

*Underdeduction* means a failure to withhold the required amount of health benefits contributions from an individual's pay, annuity, or compensation. This definition includes both nondeductions (when none of the required amounts was withheld) and partial deductions (when only part of the required amount was withheld). Though FEHB contributions are required to cover a period of nonpay status, the nonpayment of contributions during such period does not result in an underdeduction.

(b) Whenever, in this part, a period of time is stated as a number of days or a number of days from an event, the period is computed in calendar days, excluding the day of the event. Whenever, in this part, a period of time is defined by beginning and ending dates, the period includes the beginning and ending dates.

[33 FR 12510, Sept. 4, 1968]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 890.101, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov.*

### § 890.102 Coverage.

(a) Each employee, other than those excluded by paragraph (c) of this section, is eligible to be enrolled in a

health benefits plan at the time and under the conditions prescribed in this part.

(b) An employee who serves in cooperation with non-Federal agencies and is paid in whole or in part from non-Federal funds may register to be enrolled within the period prescribed by OPM for the group of which the employee is a member following approval by OPM of arrangements providing that (1) the required withholdings and contributions will be made from Federally-controlled funds and timely deposited into the Employees Health Benefits Fund, or (2) the cooperating non-Federal agency will, by written agreement with the Federal agency, make the required withholdings and contributions from non-Federal funds and transmit them for timely deposit into the Employees Health Benefits Fund.

(c) The following employees are not eligible:

(1) An employee (other than an acting postmaster, a Presidential appointee appointed to fill an unexpired term, and an appointee whose appointment meets the definition of provisional appointment set out in §§ 316.401 and 316.403 of this chapter) who is serving under an appointment limited to 1 year or less and who has not completed 1 year of current continuous employment, excluding any break in service of 5 days or less.

(2) An employee who is expected to work less than 6 months in each year, except for an employee who receives an appointment of at least 1 year's duration as an Intern under § 213.3402(a) of this chapter and who is expected to be in a pay status for at least one-third of the total period of time from the date of the first appointment to the completion of the Internship Program.

(3) An intermittent employee—a non-full-time employee without a prearranged regular tour of duty.

(4) A beneficiary or patient employee in a Government hospital or home.

(5) An employee paid on a contract or fee basis, except an employee who is a citizen of the United States who is appointed by a contract between the employee and the Federal employing authority which requires his personal service and is paid on the basis of units of time.

(6) An employee paid on a piecework basis, except one whose work schedule provides for full-time service or part-time service with a regular tour of duty.

(7) An individual first employed by the government of the District of Columbia on or after October 1, 1987. However, this exclusion does not apply to:

(i) Employees of St. Elizabeths Hospital who accept offers of employment with the District of Columbia government without a break in service, as provided in section 6 of Pub. L. 98–621 (98 Stat. 3379);

(ii) The Corrections Trustee and the Pretrial Services, Defense Services, Parole, Adult Probation and Offender Supervision Trustee and employees of these Trustees who accept employment with the District of Columbia government within 3 days after separating from the Federal Government; and

(iii) Effective October 1, 1997, judges and nonjudicial employees of the District of Columbia Courts, as provided by Pub. L. 105–33 (111 Stat. 251).

(8) An individual first employed by the government of the District of Columbia on or after October 1, 1987. However, this exclusion does not apply to:

(i) Employees of St. Elizabeths Hospital who accept offers of employment with the District of Columbia government without a break in service, as provided in section 6 of Pub. L. 98–621 (98 Stat. 3379);

(ii) The Corrections Trustee and the Pretrial Services, Parole, Adult Probation and Offender Supervision Trustee and employees of these Trustees who accept employment with the District of Columbia government within 3 days after separating from the Federal Government;

(iii) Effective October 1, 1997, judges and nonjudicial employees of the District of Columbia Courts, as provided by Pub. L. 105–33 (111 Stat. 251); and

(iv) Effective April 1, 1999, employees of the Public Defender Service of the District of Columbia, as provided by Pub. L. 105–274 (112 Stat. 2419).

(9) The following employees are not eligible to purchase a health benefit plan for which OPM contracts or which OPM approves under this paragraph (c), but may purchase health benefit plans, as defined in 5 U.S.C. 8901(6), that are

offered by an appropriate SHOP as determined by the Director, pursuant to section 1312(d)(3)(D) of the Patient Protection and Affordable Care Act, Public Law 111–148, as amended by the Health Care and Education Reconciliation Act, Public Law 111–152 (the Affordable Care Act or the Act):

(i) A Member of Congress.

(ii) A congressional staff member, if the individual is determined by the employing office of the Member of Congress to meet the definition of congressional staff member in § 890.101 as of January 1, 2014, or in any subsequent calendar year. Designation as a congressional staff member shall be an annual designation made prior to November 2013 for the plan year effective January 1, 2014 and October of each year for subsequent years or at the time of hiring for individuals whose employment begins during the year. The designation shall be made for the duration of the year during which the staff member works for the Member of Congress beginning with the January 1st following the designation and continuing to December 31st of that year.

(d) Paragraph (c) of this section does not deny coverage to:

(1) An employee appointed to perform ''part-time career employment,'' as defined in section 3401(2) of title 5, United States Code, and 5 CFR part 340, subpart B; or

(2) An employee serving under an interim appointment established under § 772.102 of this chapter.

(e) With the exception of those employees or groups of employees listed in paragraph (e)(1) of this section, the Office of Personnel Management makes the final determination of the applicability of this section to specific employees or groups of employees.

(1) Employees identified in paragraph (c)(9)(i) and (ii) of this section.

(2) [Reserved]

(f) An employee of the District of Columbia Financial Responsibility and Management Assistance Authority (the Authority) who makes an election under the Technical Corrections to Financial Responsibility and Management Assistance Act (section 153 of Pub. L. 104–134, 110 Stat. 1321) to be considered a Federal employee for health benefits and other benefit purposes is subject to this part. If the employee is eligible to make an election to enroll under § 890.301, such election must be made within 60 days after the later of either the date the employment with the Authority begins or the date the Authority receives his or her election to be considered a Federal employee. Employees of the Authority who are former Federal employees are subject to the provisions of § 890.303(a), except that a former Federal employee employed by the Authority before October 26, 1996, and within 3 days following the termination of the Federal employment may make an election to enroll under § 890.301(c). Annuitants who have continued their coverage under this part as annuitants are not eligible to enroll under this paragraph. An election to enroll under this part is effective under the provisions of § 890.306(a) unless the employee requests the Authority to make the enrollment effective on the first day of the first pay period following the date the employee entered on duty in a pay status with the Authority.

(g) Notwithstanding any other provision in this part, the hiring of a Federal employee, whether in pay status or nonpay status, for a temporary, intermittent position with the decennial census has no effect on the withholding or Government contribution for his/her coverage or the determination of when 365 days in nonpay status ends.

(h) Notwithstanding paragraphs (c)(1) and (2) of this section, an employee who is in a position identified by OPM that provides emergency response services for wildland fire protection is eligible to be enrolled in a health benefits plan under this part.

(i) Notwithstanding paragraphs (c)(1) through (3) of this section, upon request by the employing agency, OPM may grant eligibility to employees performing similar types of emergency response services to enroll in a health benefits plan under this part. In granting eligibility requests, OPM may limit the coverage of intermittent employees under a health benefits plan to the periods of time during which they are in a pay status.

(j)(1) Notwithstanding paragraphs (c)(1), (2), and (3) of this section, a non-

Postal employee working on a temporary appointment, a non-Postal employee working on a seasonal schedule of less than 6 months in a year, or a non-Postal employee working on an intermittent schedule, for whom the employing office expects the total hours in pay status (including overtime hours) plus qualifying leave without pay hours to be at least 130 hours per calendar month, is eligible to enroll in a health benefits plan under this part as follows:

(i) If the employing office expects the employee to work at least 90 days, the employee is eligible to enroll upon notification of the employee's eligibility by the employing office, and

(ii) If the employing office expects the employee to work for fewer than 90 days and the employee actually works for fewer than 90 days, the employee will generally be ineligible to enroll in FEHB because the employee will not be employed at the end of the waiting period applicable to these employees. However, if the expectation changes and the employee is expected to work for 90 days or more, that individual is eligible to enroll upon notification by the employing office, but enrollment (including the effective date of coverage) must be no later than the end of the waiting period ending the 91st day after the first day of employment.

(2) An employee working on a temporary appointment, an employee working on a seasonal schedule of less than 6 months in a year, or an employee working on an intermittent schedule for whom the employing office expects the total hours in pay status (including overtime hours) plus qualifying leave without pay hours to be less than 130 hours per calendar month is generally ineligible to enroll in a health benefits plan under this part. If the expectation of hours of employment changes to 130 hours or more per month for a non-Postal employee, that employee is eligible to enroll in a health benefits plan under this part as described in paragraph (j)(1)(i) of this section.

(3) Once an employee is enrolled under this paragraph (j), eligibility will not be revoked, regardless of his or her actual work schedule or employer expectations in subsequent years, unless the employee separates from Federal service, receives a new appointment (in which case eligibility will be determined by the rules applicable to the new appointment), or exceeds 365 days in nonpay status in accordance with §890.303(e) (subject to extension, if applicable, for qualifying leave without pay as defined at paragraph (j)(4) of this section).

(4) For purposes of this paragraph (j), ''qualifying leave without pay hours'' means hours of leave without pay for purposes of taking leave under the Family and Medical Leave Act, for performance of duty in the uniformed services under the Uniformed Services Employment and Reemployment Rights Act of 1994, 38 U.S.C. 4301 et seq., for receiving medical treatment under Executive Order 5396 (Jul. 7 1930), and for periods during which workers compensation is received under the Federal Employees Compensation Act, 5 U.S.C. chapter 81.

(5) Each temporary employee who is initially eligible for FEHB coverage on the basis of this paragraph (j) is entitled to enroll in accordance with §890.301(a). A temporary employee who is currently eligible under 5 U.S.C. 8906a (with no Government contribution) but who is not enrolled on November 17, 2014, and who would also meet eligibility requirements on the basis of paragraph (j), is entitled to enroll (with a Government contribution) on the basis of paragraph (j) in accordance with §890.301(h)(4)(ii). A temporary employee who is enrolled under 5 U.S.C. 8906a (with no Government contribution) on November 17, 2014, and who would also meet eligibility requirements on the basis of paragraph (j), is entitled to change enrollment (with a Government contribution) on the basis of paragraph (j) in accordance with §890.301(h)(4)(ii).

(k) The Director, upon written request of an employer of employees other than those covered by 5 U.S.C. 8901(1)(A), may, in his or her sole discretion, waive application of paragraph (j) of this section to its employees when the employer demonstrates to the Director that the waiver is necessary to avoid an adverse impact on the employer's need to manage its workforce. However, a Tribal employer

participating under 25 U.S.C. 1647b may provide a written notification to the Director that it has chosen not to apply paragraph (j) of this section for its workforce.

[33 FR 12510, Sept. 4, 1968]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 890.102, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

### § 890.103 Correction of errors.

(a) The employing office may make prospective corrections of administrative errors as to enrollment at any time. The employing office may make retroactive corrections of administrative errors that occur after December 31, 1994.

(b) OPM may order correction of an administrative error upon a showing satisfactory to OPM that it would be against equity and good conscience not to do so.

(c) The employing office may make retroactive correction of enrollee enrollment code errors if the enrollee reports the error by the end of the pay period following the one in which he or she received the first written documentation (i.e. pay statement or enrollment change confirmation) indicating the error.

(d) OPM may order the termination of an enrollment in any comprehensive medical plan described in section 8903(4) of title 5, United States Code, and permit the individual to enroll in another health benefits plan for purposes of this part, upon a showing satisfactory to OPM that the furnishing of adequate medical care is jeopardized by a seriously impaired relationship between a patient and the comprehensive medical plan's affiliated health care providers.

(e) Retroactive corrections are subject to withholdings and contributions under the provisions of § 890.502.

[45 FR 23637, Apr. 8, 1980, as amended at 53 FR 2, Jan. 4, 1988; 54 FR 52336, Dec. 21, 1989; 55 FR 22891, June 5, 1990; 59 FR 66437, Dec. 27, 1994; 62 FR 38435, July 18, 1997]

### § 890.104 Initial decision and reconsideration on enrollment.

(a) *Who may file.* Except as provided under § 890.1112, an individual may request an agency or retirement system to reconsider an initial decision of its employing office denying coverage or change of enrollment.

(b) *Initial employing office decision.* An employing office's decision is considered an initial decision as used in paragraph (a) of this section when rendered by the employing office in writing and stating the right to an independent level of review (reconsideration) by the agency or retirement system. However, an initial decision rendered at the highest level of review available within OPM is not subject to reconsideration.

(c) *Reconsideration.* (1) A request for reconsideration must be made in writing, must include the claimant's name, address, date of birth, Social Security number, name of carrier, reason(s) for the request, and, if applicable, retirement claim number.

(2) The reconsideration review must be an independent review designated at or above the level at which the initial decision was rendered.

(d) *Time limit.* A request for reconsideration of an initial decision must be filed within 30 calendar days from the date of the written decision stating the right to a reconsideration. The time limit on filing may be extended when the individual shows that he or she was not notified of the time limit and was not otherwise aware of it, or that he or she was prevented by circumstances beyond his or her control from making the request within the time limit. An agency or retirement system decision in response to a request for reconsideration of an employing office's decision is a final decision as described in paragraph (e) of this section.

(e) *Final decision.* After reconsideration, the agency or retirement system must issue a final decision, which must be in writing and must fully set forth the findings and conclusions.

[59 FR 66437, Dec. 27, 1994]

### § 890.105 Filing claims for payment or service.

(a) *General.* (1) Each health benefits carrier resolves claims filed under the plan. All health benefits claims must be submitted initially to the carrier of the covered individual's health benefits plan. If the carrier denies a claim (or a

portion of a claim), the covered individual may ask the carrier to reconsider its denial. If the carrier affirms its denial or fails to respond as required by paragraph (c) of this section, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the carrier and OPM review processes specified in this section before seeking judicial review of the denied claim.

(2) This section applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) *Time limits for reconsidering a claim.* (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the carrier in which to submit a written request for reconsideration to the carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the carrier's notice requesting additional information. The carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this section if the carrier fails to act within the time limit set forth in this paragraph (b)(2)(iii).

(3) The covered individual may write to OPM and request that OPM review the carrier's decision if the carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this section. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this section.

(4) The carrier may extend the time limit for a covered individual's submission of additional information to the carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) *Information required to process requests for reconsideration.* (1) The covered individual must put the request to the carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) *Carrier determinations.* The carrier must provide written notice to the covered individual of its determination. If the carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) *OPM review.* (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the carrier's notice to the covered individual that the denial was affirmed;

(ii) If the carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this section, within 120 days after the date of the covered individual's timely request for reconsideration by the carrier; or

(iii) Within 120 days after the date the carrier requests additional information from the covered individual, or the date the covered individual is notified that the carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the carrier, OPM may:

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the carrier, the carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this section, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the carrier.

(5) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

[61 FR 15178, Apr. 5, 1996]

### § 890.106 Carrier entitlement to pursue subrogation and reimbursement recoveries.

(a) All health benefit plan contracts shall provide that the Federal Employees Health Benefits (FEHB) carrier is entitled to pursue subrogation and reimbursement recoveries, and shall have a policy to pursue such recoveries in accordance with the terms of this section.

(b)(1) Any FEHB carriers' right to pursue and receive subrogation and reimbursement recoveries constitutes a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage.

(2) Any health benefits plan contract that contains a subrogation or reimbursement clause shall provide that benefits and benefit payments are extended to a covered individual on the condition that the FEHB carrier may pursue and receive subrogation and reimbursement recoveries pursuant to the contract.

(c) Contracts shall provide that the FEHB carriers' rights to pursue and receive subrogation or reimbursement recoveries arise upon the occurrence of the following:

(1) The covered individual has received benefits or benefit payments as a result of an illness or injury; and

(2) The covered individual has accrued a right of action against a third party for causing that illness or injury; or has received a judgment, settlement or other recovery on the basis of that

illness or injury; or is entitled to receive compensation or recovery on the basis of the illness or injury, including from insurers of individual (non-group) policies of liability insurance that are issued to and in the name of the enrollee or a covered family member.

(d) A FEHB carrier's exercise of its right to pursue and receive subrogation or reimbursement recoveries does not give rise to a claim within the meaning of 5 CFR 890.101 and is therefore not subject to the disputed claims process set forth at 5 CFR 890.105.

(e) Any subrogation or reimbursement recovery on the part of a FEHB carrier shall be effectuated against the recovery first (before any of the rights of any other parties are effectuated) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned.

(f) Pursuant to a subrogation or reimbursement clause, the FEHB carrier may recover directly from any party that may be liable, or from the covered individual, or from any applicable insurance policy, or a workers' compensation program or insurance policy, all amounts available to or received by or on behalf of the covered individual by judgment, settlement, or other recovery, to the extent of the amount of benefits that have been paid or provided by the carrier.

(g) Any contract must contain a provision incorporating the carrier's subrogation and reimbursement rights as a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under the plan's coverage. The corresponding health benefits plan brochure must contain an explanation of the carrier's subrogation and reimbursement policy.

(h) A carrier's rights and responsibilities pertaining to subrogation and reimbursement under any FEHB contract relate to the nature, provision, and extent of coverage or benefits (including payments with respect to benefits) within the meaning of 5 U.S.C. 8902(m)(1). These rights and responsibilities are therefore effective notwithstanding any state or local law, or any regulation issued thereunder, which relates to health insurance or plans.

[80 FR 29204, May 21, 2015]

### § 890.107 Court review.

(a) A suit to compel enrollment under § 890.102 must be brought against the employing office that made the enrollment decision.

(b) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(c) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (5 U.S.C. chapter 89). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the carrier or carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute.

(d) An action under paragraph (c) of this section to recover on a claim for health benefits:

(1) May not be brought prior to exhaustion of the administrative remedies provided in § 890.105;

(2) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(3) Will be limited to the record that was before OPM when it rendered its decision affirming the carrier's denial of benefits.

[61 FR 15179, Apr. 5, 1996]

### § 890.108 Will OPM waive requirements for continued coverage during retirement?

(a) Under 5 U.S.C. 8905(b), OPM may waive the eligibility requirements for health benefits coverage as an annuitant for an individual when, in its sole discretion, it determines that due to exceptional circumstances it would be against equity and good conscience not to allow a person to be enrolled in the FEHB Program as an annuitant.

(b) The individual's failure to satisfy the eligibility requirements must be

due to exceptional circumstances. An individual requesting a waiver must provide OPM with evidence that:

(1) The individual intended to have FEHB coverage as an annuitant (retiree);

(2) The circumstances that prevented the individual from meeting the requirements of 5 U.S.C. 8905(b) were beyond the individual's control; and

(3) The individual acted reasonably to protect his or her right to continue coverage into retirement.

[72 FR 19100, Apr. 17, 2007]

### § 890.109 Exclusion of certain periods of eligibility when determining continued coverage during retirement.

(a) Except as provided in paragraph (b) of this section, periods during which temporary employees are eligible under 5 U.S.C. 8906a to receive health benefits by enrolling and paying the full subscription charge, but are not eligible to participate in a retirement system, are not considered when determining eligibility for continued coverage during retirement. For the purpose of continuing coverage during retirement, an employee is considered to have enrolled at his or her first opportunity if the employee registered to be enrolled when he or she received a permanent appointment entitling him or her to participate in a retirement system and to receive the Government contribution toward the health benefits premium payments.

(b) A temporary employee eligible under 5 U.S.C. 8906a may continue enrollment as a compensationer if he or she has been enrolled or covered as a family member under another enrollment under this part for:

(1) The 5 years of service immediately preceding the commencement of his or her monthly compensation; or

(2) During all periods of service since his or her first opportunity to enroll, if less than 5 years. For the purpose of this paragraph, an employee is considered to have enrolled at his or her first opportunity if the employee registered to be enrolled when he or she first became eligible under 5 U.S.C. 8906a.

[58 FR 47824, Sept. 13, 1993]

### § 890.110 Enrollment reconciliation.

(a) Each employing office must report to each carrier or its surrogate on a quarterly basis the names of the individuals who are enrolled in the carrier's plan in a format and containing such information as required by OPM.

(b) The carrier must compare the data provided with its own enrollment records. When the carrier finds in its total enrollment records individuals whose names do not appear in the report from the employing office of record, the carrier must request the employing office to provide the documentation necessary to resolve the discrepancy.

[63 FR 59459, Nov. 4, 1998; 63 FR 64761, Nov. 23, 1998]

### § 890.111 Continuation of eligibility for former Federal employees of the Civilian Marksmanship Program.

(a) A Federal employee who was employed by the Department of Defense to support the Civilian Marksmanship Program as of the day before the date of the transfer of the Program to the Corporation for the Promotion of Rifle Practice and Firearms Safety, and was offered and accepted employment by the Corporation as part of the transition described in section 1612(d) of Public Law 104–106, 110 Stat. 517, is deemed to be an employee for purposes of this part during continuous employment with the Corporation unless the individual files an election under § 831.206(c) or § 842.109(c) of this title. Such a covered individual is treated as if he or she were a Federal employee for purposes of this part, and of any other part within this title relating to the FEHB Program. The individual is entitled to the benefits of, and is subject to all conditions under, the FEHB Program on the same basis as if the individual were an employee of the Federal Government.

(b) Cessation of employment with the Corporation for any period terminates eligibility for coverage under the FEHB Program as an employee during any subsequent employment by the Corporation.

(c) The Corporation must withhold from the pay of an individual described by paragraph (a) of this section an

amount equal to the premiums withheld from the pay of a Federal employee for FEHB coverage and, in accordance with procedures established by OPM, pay into the Employees Health Benefits Fund the amounts deducted from the individual's pay.

(d) The Corporation must, in accordance with procedures established by OPM, pay into the Employees Health Benefits Fund amounts equal to any agency contributions required under the FEHB Program.

[74 FR 66567, Dec. 16, 2009]

### § 890.112 Continuation of coverage for certain Senate Restaurants employees.

(a) A Senate Restaurants employee who was an employee of the Architect of the Capitol on July 17, 2008, who accepted employment with the private business concern to which the Senate Restaurants' food service operations were transferred as described in section 1 of Public Law 110–279, and who elected to continue his or her Federal employee retirement benefits is deemed to be an employee for purposes of this part during continuous employment with the private business concern or its successor. The individual shall be entitled to the benefits of, and be subject to all conditions under, the FEHB Program on the same basis as if the individual were an employee of the Federal Government.

(b) Cessation of employment with the private business concern or its successor for any period terminates eligibility for coverage under the FEHB Program as an employee during any subsequent employment by the private business concern.

(c) The private business concern or its successor must make arrangements for the withholding from pay of an individual described by paragraph (a) of this section of an amount equal to the premiums withheld from Federal employees' pay for FEHB coverage and, in accordance with procedures established by OPM, pay into the Employees Health Benefits Fund the amounts deducted from the individual's pay.

(d) The private business concern or its successor shall, in accordance with procedures established by OPM, pay into the Employees Health Benefits Fund amounts equal to any agency contributions required under the FEHB Program.

[75 FR 76616, Dec. 9, 2010]

## Subpart B—Health Benefits Plans

### § 890.201 Minimum standards for health benefits plans.

(a) To qualify for approval by OPM, a health benefits plan shall meet the following standards. Once approved, a health benefits plan shall continue to meet the minimum standards. Failure on the part of the carrier's plan to meet the standards is cause for OPM's withdrawal of approval of the plan in accordance with 5 CFR 890.204. A health benefits plan shall:

(1) Comply with chapter 89 of title 5, United States Code, and this part, as amended from time to time.

(2) Accept the enrollment, in accordance with this part, and without regard to age, race, sex, health status, or hazardous nature of employment, of each eligible employee, annuitant, former spouse, former employee, or child, except that a plan that is sponsored or underwritten by an employee organization may not accept the enrollment of a person who is not a member of the organization, but it may not limit membership in the organization on account of the prohibited factors (age, race, sex, health status, or hazardous nature of employment). The carrier may terminate the enrollment of an enrollee other than a survivor annuitant, a former spouse continuing coverage under § 890.803, or person continuing coverage under § 890.1103(a) (2) or (3), in a health benefits plan sponsored or underwritten by an employee organization on account of termination of membership in the organization. A carrier that wants to terminate the enrollment of an enrollee under this paragraph may do so by notifying the employing office in writing, with a copy of the notice to the enrollee. The termination is effective at the end of the pay period in which the employing office receives the notice. A comprehensive medical plan need not enroll an employee, annuitant, former employee, former spouse, or child residing outside the geographic areas specified by the plan.

(3) Provide health benefits for each enrollee and covered family member wherever they may be.

(4) Provide for conversion to a contract for health benefits regularly offered by the carrier, or an appropriate affiliate, for group conversion purposes, which must be guaranteed renewable, subject to such amendments as apply to all contracts of this class, except that it may be canceled for fraud, overinsurance, or nonpayment of periodic charges. A carrier must permit conversion within the time allowed by the temporary extension of coverage provided under § 890.401 for each enrollee and covered family member entitled to convert. When an employing office gives an enrollee written notice of his or her privilege of conversion, the carrier must permit conversion at any time before 31 days after the date of notice or 91 days after the enrollment is terminated, whichever is earlier. Belated conversion opportunities as provided in § 890.401(c) must also be permitted by the carrier. When OPM requests an extension of time for conversion because of delayed determination of ineligibility for immediate annuity, the carrier must permit conversion until the date specified by OPM in its request for extension. On conversion, the contract becomes effective as of the day following the last day of the temporary extension, and the enrollee or covered family member, as the case may be, must pay the entire cost thereof directly to the carrier. The nongroup contract may not deny or delay any benefit covered by the contract for a person converting from a plan approved under this part except to the extent that benefits are continued under the health benefits plan from which he or she converts.

(5) Provide that each enrollee receive an identification card or cards or other evidence of enrollment.

(6) Provide a standard rate structure that contains, for each option, one standard self only rate, one standard self plus one rate and one standard self and family rate.

(7) Maintain statistical records regarding the plan, separately from those of any other activities conducted or benefits offered by the carrier sponsoring or underwriting the plan.

(8) Provide for a special reserve for the plan. The carrier shall account for amounts retained by it as reserves for the plan separately from reserves maintained by it for other plans. The carrier shall invest the special reserve and income derived from the investment of the special reserve shall be credited to the special reserve. If the contract is terminated or approval of the plan is withdrawn, the carrier shall return the special reserve to the Employees Health Benefits Fund. However, in the case of a comprehensive medical plan, the carrier, without regard to the foregoing provisions of this paragraph, shall follow such financial procedures as are mutually agreed on by the carrier and OPM.

(9) Provide for continued enrollment to the end of the current pay period, or termination date, if earlier, of each enrollee enrolled at the effective date of termination of a contract. The carrier is entitled to subscription charges for this continued enrollment.

(10) Provide that any covered expenses incurred from January 1 to the effective date of an open season change count toward the losing carrier's prior year deductible. If the prior year deductible or family limit on deductibles of the losing carrier had previously been met, the enrolled individual (and eligible family members) shall be eligible for reimbursement by the losing carrier for covered expenses incurred during the current year. Reimbursement of covered expenses shall apply only to covered expenses incurred from January 1 to the effective date of the open season change. This section shall not apply to any other permissible changes made during a contract year.

(11) Except where OPM determines otherwise, have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan at some time during the preceding two contract terms.

(b) To be qualified to be approved by OPM and, once approved, to continue to be approved, a health benefits plan shall not:

(1) Deny a covered person a benefit provided by the plan for a service performed on or after the effective date of coverage solely because of a preexisting physical or mental condition.

(2) Require a waiting period for any covered person for benefits which it provides.

(3)(i) Have either more than three options, or more than two options and a high deductible health plan (26 U.S.C. 223(c)(2)(A)) if the plan is described under 5 U.S.C. 8903(1), (2), (3) or (4).

(ii) [Reserved]

(4) Have an initiation, service, enrollment, or other fee or charge in addition to the rate charged for the plan, except that a comprehensive medical plan may impose an additional charge to be paid directly by the enrollee for certain medical supplies and services, if the supplies and services on which additional charges are imposed are clearly set forth in advance and are applicable to all enrollees. This subparagraph does not apply to charges for membership in employee organizations sponsoring or underwriting plans.

(5) Paragraphs (b)(1) and (2) of this section do not preclude a plan offering benefits for dentistry or cosmetic surgery, or both, limited to conditions arising after the effective date of coverage.

(c) The Director or his or her designee will determine whether to propose withdrawal of approval of the plan and hold a hearing based on the seriousness of the carrier's actions and its proposed method to effect corrective action.

(d) Nothing in this part shall limit or prevent a health insurance plan purchased through an appropriate SHOP as determined by the Director, pursuant to section 1312(d)(3)(D) of the Patient Protection and Affordable Care Act, Public Law 111–148, as amended by the Health Care and Education Reconciliation Act, Public Law 111–152 (the Affordable Care Act or the Act), by an employee otherwise covered by 5 U.S.C. 8901(1)(B) and (C) from being considered a ''health benefit plan under this chapter'' for purposes of 5 U.S.C. 8905(b) and 5 U.S.C. 8906.

[33 FR 12510, Sept. 4, 1968, as amended at 43 FR 52460, Nov. 13, 1978; 47 FR 14871, Apr. 6, 1982; 49 FR 48905, Dec. 17, 1984; 52 FR 10217, Mar. 31, 1987; 54 FR 52336, Dec. 21, 1989; 55 FR 9108, Mar. 12, 1990; 55 FR 22891, June 5, 1990; 69 FR 31721, June 7, 2004; 75 FR 76616, Dec. 9, 2010; 78 FR 60656, Oct. 2, 2013; 80 FR 55734, Sept. 17, 2015; 83 FR 18401, Apr. 27, 2018]

### § 890.202 Minimum standards for health benefits carriers.

The minimum standards for health benefits carriers for the FEHB Program shall be those contained in 48 CFR subpart 1609.70.

[57 FR 14324, Apr. 20, 1992]

### § 890.203 Application for approval of, and proposal of amendments to, health benefit plans.

(a) *New plan applications.* (1) The Director of OPM shall consider applications to participate in the FEHB Program from comprehensive medical plans (CMP's) at his or her discretion. CMP's are automatically invited to submit applications annually to participate in the FEHB Program unless otherwise notified by OPM. If the Director should determine that it is not beneficial to the enrollees and the Program to consider applications for a specific contract year, OPM will publish a notice with a 60 day comment period in the FEDERAL REGISTER no less than 7 months prior to the date applications would be due for the specific contract year for which applications will not be accepted.

(2) When applications are considered, CMP's should apply for approval by writing to the Office of Personnel Management, Washington, DC 20415. Application letters must be accompanied by any descriptive material, financial data, or other documentation required by OPM. Plans must submit the letter and attachments in the OPM-specified format by January 31, or another date specified by OPM, of the year preceding the contract year for which applications are being accepted. Plans must submit evidence demonstrating they meet all requirements for approval by March 31 of the year preceding the contract year for which applications are being accepted. Plans that miss either deadline cannot be considered for participation in the next contract year. All newly approved plans must submit benefit and rate proposals to OPM by May 31 of the year preceding the contract year for which applications are being accepted in order to be considered for participation in that contract year. OPM may make counter-proposals at any time.

(3) OPM may approve such comprehensive medical plans as, in the judgment of OPM, may be in the best interest of enrollees in the Program. In addition to specific requirements set forth in 5 U.S.C. chapter 89, in chapter 1 and other relevant portions of title 48 of the Code of Federal Regulations, and in other sections of this part, to be approved, an applicant plan must actually be delivering medical care at the time of application; must be in compliance with applicable State licensing and operating requirements; must not be a Federal, State, local, or territorial governmental entity; and must not be debarred, suspended, or ineligible to participate in Government contracting or subcontracting for any reason, including fraudulent health care practices in other Federal health care programs.

(4) Applications must identify those individuals who have the legal authority and responsibility to enter into and guarantee contracts. The applications will be reviewed for evidence of substantial compliance with the following standards:

(i) *Health plan management:* Stable management with experience pertinent to the prepaid health care provider industry; sufficient operating experience to enable OPM to realistically evaluate the plan's past and expected future performance;

(ii) *Marketing:* A rate of enrollment that ensures equalization of income and expenses within projected timeframes and sufficient subscriber income to operate within budget thereafter; enrollment dispersed among groups such that there is not a concentration of enrollment with one or a few groups so that the loss of one or more contracts by the carrier would not jeopardize its financial viability; feasible projections of future enrollment and employer distribution, as well as the potential enrollment area for marketing purposes;

(iii) *Health care delivery system:* A health care delivery system providing reasonable access to and choice of quality primary and specialty medical care throughout the service area; specifically, in the individual practice setting, contractual arrangements for the services of a significant number of primary care and specialty physicians in the service area; and in the group practice setting, compliance with 5 U.S.C. 8903(4)(A) preferably demonstrated by full-time providers specializing in internal medicine, family practice, pediatrics, and obstetrics/gynecology; and

(iv) *Financial condition:* Establishment of firm budget projections and demonstrated success in meeting or exceeding those projections on a regular basis; evidence of the ability to sustain operation in the future and to meet obligations under the contract OPM might enter into with the plan; clearly specified committed funding to see the plan to an expected break-even point including a sufficient amount for unexpected contingencies; adequate current and projected funding, such as estimated premium income or commitment from a financially sound and acceptable parent organization or a mature stable entity outside the plan; insolvency protection, such as stop-loss reinsurance services and agreements with all plan providers that they will hold members harmless if, for any reason, the plan is unable to pay its providers.

(5) A comprehensive medical plan that has been certified either as a qualified Health Maintenance Organization (HMO) or as a qualified Competitive Medical Plan by the Department of Health and Human Services (HHS) at the time of application to OPM, and whose qualification status is not under investigation by HHS, will need to submit only an abbreviated application to OPM. The extent of the data and documentation to be submitted by a plan so qualified by HHS, as well as by a non-qualified plan, for a particular review cycle may be obtained by writing directly to the Office of Insurance Programs, Retirement and Insurance Service, Office of Personnel Management, Washington, DC 20415.

(b) *Participating plans.* Changes in rates and benefits for approved health benefits plans shall be considered at the discretion of the Director of OPM. If the Director of OPM determines that it is beneficial to enrollees and the Federal Employees Health Benefits Program to invite health plan benefit and/or rate changes for a given contract period, a ''call letter'' shall be

issued to the carrier approximately 9 months prior to the expiration of the current contract period. Any proposal for change shall be in writing, specifically describe the change proposed, and be signed by an authorized official of the carrier. OPM will review any requested proposal for change and will notify the carrier of its decision to accept or reject the change. OPM may make a counter proposal or at any time propose changes on its own motion. Benefits changes and rate proposals, when requested by OPM, shall be submitted not less than 7 months before the expiration of the then current contract period, unless the Director of OPM determines that a later date is acceptable. The negotiation period shall begin approximately 7 months before the expiration of the current contract period, and OPM shall seek to complete all benefit and rate negotiations no later than 4 months preceding the contract period to which they will apply. If OPM and the carrier do not reach agreement by this date, either party may give written notice of nonrenewal in accordance with § 890.205 of this part.

[37 FR 20668, Oct. 3, 1972, as amended at 41 FR 40090, Sept. 17, 1976; 43 FR 52461, Nov. 13, 1978; 48 FR 16232, Apr. 15, 1983; 50 FR 8315, Feb. 28, 1985; 52 FR 23934, June 26, 1987; 54 FR 52337, Dec. 21, 1989; 55 FR 22891, June 5, 1990; 57 FR 19374, May 6, 1992; 59 FR 62284, Dec. 5, 1994; 60 FR 62988, Dec. 8, 1995]

### § 890.204 Withdrawal of approval of health benefits plans or carriers.

(a) The Director may withdraw approval of a health benefits plan or carrier if the standards at § 890.201 of this part and 48 CFR subpart 1609.70 are not met. Such action carries with it the right to a hearing as provided in paragraph (a)(2) of this section.

(1) Before withdrawing approval, the Director or his or her representative shall notify the carrier of the plan, by certified mail, that OPM intends to withdraw approval of the health benefits plan and/or carrier. The notice shall set forth the reasons why approval is to be withdrawn. The carrier is entitled to reply in writing within 15 calendar days after its receipt of the notice, stating the reasons why approval should not be withdrawn.

(2) On receipt of the reply, or in the absence of a timely reply, the Director or representative shall set a date, time, and place for a hearing. The carrier shall be notified by certified mail at least 15 calendar days in advance of the hearing. The hearing officer shall be the Director, or a representative designated by the Director, who shall not otherwise have been a party to the initial administrative decision to issue a letter of intent to withdraw the plan's or carrier's approval. The hearing officer shall conduct the hearing unless it is waived in writing by the carrier. The carrier is entitled to appear by representative and present oral or documentary evidence, including rebuttal evidence, in opposition to the proposed action.

(i) A transcribed record shall be kept of the hearing and shall be the exclusive record of the proceeding.

(ii) After the hearing is held, or after OPM's receipt of the carrier's written waiver of the hearing, the Director shall make a decision on the record, taking into consideration any recommendation submitted by the hearing officer, and send it to the carrier by certified mail. A decision of the Director shall be considered a final decision for the purposes of this section. The Director, or his or her representative, may set a future effective date for withdrawal of approval.

(3) The Director, or his or her representative, may give written notice of non-renewal of the contract of a carrier whose plan does not meet the minimum enrollee requirement in § 890.201(a)(11). However, the Director may defer withdrawing approval of a plan not meeting the requirement in § 890.201(a)(11) of this part when, in the judgment of OPM, the carrier shows good cause. The Director or representative may authorize a plan with fewer than 300 employees or annuitants to remain in the FEHB Program when he or she determines, in his or her discretion, that it is in the best interest of the Program (e.g., when the plan is the only plan available to enrollees in a rural area).

(b) During a current contract term, the Director, in his or her discretion, may reinstate approval of a plan or carrier under this section on a finding

that the reasons for withdrawing approval no longer exist.

[55 FR 9109, Mar. 12, 1990, as amended at 57 FR 14324, Apr. 20, 1992]

### § 890.205 Nonrenewal of contracts of health benefits plans.

(a) Either OPM or the carrier may terminate a contract by giving a written notice of nonrenewal which includes an indication of the reason for the intended action.

(b) Where termination by notice of intent not to renew is made by OPM, the carrier contesting that notice may request that OPM review the proposed decision. Such review shall be conducted by the Director or a representative designated by the Director, who shall not otherwise have been a party to the initial decision to issue a notice of intent not to renew. A request for such review, which may include a request that a representative of the carrier appear personally before OPM, shall be in writing. That request must be received within 10 calendar days of the carrier's receipt of the notice of intent not to renew. Such request shall include a detailed statement as to why the carrier disagrees with OPM's notice of nonrenewal and shall be accompanied by appropriate supporting documentation. Where a carrier has requested review under this section, the final decision by OPM not to renew a health benefits contract shall be communicated to the carrier in writing not more than 30 days after OPM's receipt of the carrier's request for review, unless a later date is mutually agreed upon.

(c) In the absence of a timely request for review as set forth in paragraph (b) of this section, OPM's notice of intent not to renew will become final without further notification.

[57 FR 19374, May 6, 1992]

## Subpart C—Enrollment

### § 890.301 Opportunities for employees who are not participants in premium conversion to enroll or change enrollment; effective dates.

(a) *Initial opportunity to enroll.* An employee who becomes eligible may elect to enroll or not to enroll within 60 days after becoming eligible.

(b) *Effective date—generally.* Except as otherwise provided, an enrollment or change of enrollment takes effect on the first day of the first pay period that begins after the date the employing office receives an appropriate request to enroll or change the enrollment and that follows a pay period during any part of which the employee is in pay status.

(c) *Belated enrollment.* When an employing office determines that an employee was unable, for cause beyond his or her control, to enroll or change the enrollment within the time limits prescribed by this section, the employee may enroll or change the enrollment within 60 days after the employing office advises the employee of its determination.

(d) *Enrollment by proxy.* Subject to the discretion of the employing office, an employee's representative, having written authorization to do so, may enroll or change the enrollment for the employee.

(e) *Decreasing enrollment type.* (1) Subject to two exceptions, an employee may decrease enrollment type at any time. *Exceptions:*

(i) An employee participating in health insurance premium conversion may decrease enrollment type during an open season or because of and consistent with a qualifying life event as defined in part 892 of this chapter.

(ii) An employee who is subject to a court or administrative order as discussed in paragraph (g)(3) of this section may not decrease enrollment type in a way that eliminates coverage of a child identified in the order as long as the court or administrative order is still in effect and the employee has at least one child identified in the order who is still eligible under the FEHB Program, unless the employee provides documentation to the agency that he or she has other coverage for the child(ren). The employee may not elect self only as long as he or she has one child identified as covered, but may elect self plus one.

(2) A decrease in enrollment type takes effect on the first day of the first pay period that begins after the date

the employing office receives an appropriate request to change the enrollment, except that at the request of the enrollee and upon a showing satisfactory to the employing office that there was no family member eligible for coverage under the self plus one or self and family enrollment, or only one family member eligible for coverage under the self and family enrollment, as appropriate, the employing office may make the change effective on the first day of the pay period following the one in which there was, in the case of a self plus one enrollment, no family member or, in the case of a self and family enrollment, only one or no family member.

(f) *Open season.* (1) An open season will be held each year from the Monday of the second full workweek in November through the Monday of the second full workweek in December.

(2) The Director of the Office of Personnel Management may modify the dates specified in paragraph (f)(1) of this section or hold additional open seasons.

(3) With one exception, during an open season, an eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, may change from one plan or option to another, or may make any combination of these changes. *Exception:* An employee who is subject to a court or administrative order as discussed in paragraph (g)(3) of this section may not cancel his or her enrollment, decrease enrollment type, or change to a comprehensive medical plan that does not serve the area where his or her child or children live as long as the court or administrative order is still in effect, and the employee has at least one child identified in the order who is still eligible under the FEHB Program, unless the employee provides documentation to the agency that he or she has other coverage for the child(ren). The employee may not elect self only as long as he or she has one child identified as covered, but may elect self plus one.

(4)(i) An open season new enrollment takes effect on the first day of the first pay period that begins in the next following year and which follows a pay period during any part of which the employee is in a pay status.

(ii) An open season change of enrollment takes effect on the first day of the first pay period which begins in January of the next following year.

(5) When a belated open season enrollment or change of enrollment is accepted by the employing office under paragraph (c) of this section, it takes effect as required by paragraph (f)(4) of this section.

(g) *Change in family status.* (1) An eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the employee's family status changes, including a change in marital status or any other change in family status. The employee must enroll or change the enrollment within the period beginning 31 days before the date of the change in family status, and ending 60 days after the date of the change in family status.

(2) An enrollment or change of enrollment made in conjunction with the birth of a child, or the addition of a child as a new family member in some other manner, takes effect on the first day of the pay period in which the child is born or becomes an eligible family member.

(3)(i) If an employing office receives a court or administrative order on or after October 30, 2000, requiring an employee to provide health benefits for his or her child or children, the employing office will determine if the employee has a self plus one or self and family enrollment, as appropriate, in a health benefits plan that provides full benefits in the area where the child or children live. If the employee does not have the required enrollment, the agency must notify him or her that it has received the court or administrative order and give the employee until the end of the following pay period to change his or her enrollment or provide documentation to the employing office that he or she has other coverage for the child or children. If the employee does not comply within these time frames, the employing office must enroll the employee involuntarily as stated in paragraph (g)(3)(ii) of this section.

(ii) If the employee is not enrolled or does not enroll, the agency must enroll

him or her for self plus one or self and family coverage, as appropriate, in the option that provides the lower level of coverage in the Service Benefit Plan. If the employee is enrolled but does not increase the enrollment type in a way that is sufficient to cover the child or children, the employing office must change the enrollment to self plus one or self and family, as appropriate, in the same option and plan, as long as the plan provides full benefits in the area where the child or children live. If the employee is enrolled in a comprehensive medical plan that does not serve the area in which the child or children live, the employing office must change the enrollment to self plus one or self and family, as appropriate, in the option that provides the lower level of coverage in the Service Benefit Plan.

(4) Subject to two exceptions, the effective date of an involuntary enrollment under paragraph (g)(3) of this section is the 1st day of the pay period that begins after the date the employing office completes the enrollment request. *Exceptions:*

(i) If the court or administrative order requires an earlier effective date, the effective date will be the 1st day of the pay period that includes that date. Effective dates may not be retroactive to a date more than 2 years earlier, or prior to October 30, 2000.

(ii) If after an involuntary enrollment becomes effective and the employing office finds that circumstances beyond the employee's control prevented him or her from enrolling or changing the enrollment within the time limits in this section, the employee may change the enrollment prospectively within 60 days after the employing office advises the employee of its finding.

(h) *Change in employment status.* An eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the employee's employment status changes. Except as otherwise provided, an employee must enroll or change the enrollment within 60 days after the change in employment status. Employment status changes include, but are not limited to—

(1) A return to pay status following loss of coverage under either—

(i) Section 890.304(a)(1)(v) due to the expiration of 365 days in leave without pay (LWOP) status, or

(ii) Section 890.502(b)(5) due to the termination of coverage during LWOP status.

(2) Reemployment after a break in service of more than 3 days.

(3) Restoration to a civilian position after serving in the uniformed services under conditions that entitle him or her to benefits under part 353 of this chapter, or similar authority.

(4)(i) A change from a temporary appointment in which the employee is eligible to enroll under 5 U.S.C. 8906a, which requires payment of the full premium with no Government contribution, to an appointment that entitles the employee to receive the Government contribution.

(ii) A change in entitlement to Government contribution as a result of becoming eligible for coverage under § 890.102(j).

(5) Separation from Federal employment when the employee or the employee's spouse is pregnant and the employee supplies medical documentation of the pregnancy. An employee who enrolls or changes the enrollment under this paragraph (h)(5) must do so during his or her final pay period. The effective date of an enrollment or a change of enrollment under this paragraph (h)(5) is the first day of the pay period which the employing office receives an appropriate request to enroll or change the enrollment.

(6) A transfer from a post of duty within a State of the United States or the District of Columbia to a post of duty outside a State of the United States or the District of Columbia, or the reverse. An employee who enrolls or changes the enrollment under this paragraph (h)(6) must do so within the period beginning 31 days before leaving the old post of duty and ending 60 days after arriving at the new post of duty.

(7) A change, without a break in service or after a separation of 3 days or less, to part-time career employment as defined in 5 U.S.C. 3401(2) and 5 CFR part 340, subpart B, or a change from

such part-time career employment to full-time employment that entitles the employee to the full Government contribution.

(i) *Loss of coverage under this part or under another group insurance plan.* An eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the employee or an eligible family member of the employee loses coverage under this part or another group health benefits plan. Except as otherwise provided, an employee must enroll or change the enrollment within the period beginning 31 days before the date of loss of coverage, and ending 60 days after the date of loss of coverage. Losses of coverage include, but are not limited to—

(1) Loss of coverage under another FEHB enrollment due to the termination, cancellation, or a change to self plus one or to self only, of the covering enrollment.

(2) Loss of coverage under another federally-sponsored health benefits program.

(3) Loss of coverage due to the termination of membership in an employee organization sponsoring or underwriting an FEHB plan.

(4) Loss of coverage due to the discontinuance of an FEHB plan in whole or in part. For an employee who loses coverage under this paragraph (i)(4):

(i) If the discontinuance is at the end of a contract year, the employee must change the enrollment during the open season, unless OPM establishes a different time. If the discontinuance is at a time other than the end of the contract year, OPM must establish a time and effective date for the employee to change the enrollment.

(ii) If the whole plan is discontinued, an employee who does not change the enrollment within the time set in (i)(4)(i) of this section will be enrolled in the lowest-cost nationwide plan option, as defined in paragraph (n) of this section;

(iii) If one or more options of a plan are discontinued, an employee who does not change the enrollment will be enrolled in the remaining option of the plan, or in the case of a plan with two or more options remaining, the lowest-cost remaining option that is not a High Deductible Health Plan (HDHP).

(iv) If the discontinuance of the plan, whether permanent or temporary, is due to a disaster, an employee must change the enrollment within 60 days of the disaster, as announced by OPM. If an employee does not change the enrollment within the time frame announced by OPM, the employee will be enrolled in the lowest-cost nationwide plan option, as defined in paragraph (n) of this section. The effective date of enrollment changes under this provision will be set by OPM when it makes the announcement allowing such changes;

(v) An employee who is unable, for causes beyond his or her control, to make an enrollment change within the 60 days following a disaster and is, as a result, enrolled in the lowest-cost nationwide plan as defined in paragraph (n) of this section, may request a belated enrollment into the plan of his or her choice subject to the requirements of paragraph (c) of this section;

(5) Loss of coverage under the Medicaid program or similar State-sponsored program of medical assistance for the needy.

(6) Loss of coverage under a non-Federal health plan because an employee moves out of the commuting area to accept another position and the employee's non-federally employed spouse terminates employment to accompany the employee. An employee may enroll or change the enrollment within the period beginning 31 days before the date the employee leaves employment in the old commuting area and ending 180 days after entry on duty at place of employment in the new commuting area.

(7) Loss of coverage under a non-Federal health plan.

(j) *Move from comprehensive medical plan's area.* An employee in a comprehensive medical plan who moves or becomes employed outside the geographic area from which the plan accepts enrollments, or if already outside this area, moves or becomes employed further from this area, may change the enrollment upon notifying the employing office of the move or change of place of employment. Similarly, an

employee whose covered family member moves outside the geographic area from which the plan accepts enrollments, or if already outside this area, moves further from this area, may change the enrollment upon notifying the employing office of the family member's move. The change of enrollment takes effect on the first day of the pay period that begins after the employing office receives an appropriate request.

(k) *On becoming eligible for Medicare.* An employee may change the enrollment from one plan or option to another at any time beginning on the 30th day before becoming eligible for coverage under title XVIII of the Social Security Act (Medicare). A change of enrollment based on becoming eligible for Medicare may be made only once.

(l) *Salary of temporary employee insufficient to pay withholdings.* If the salary of a temporary employee eligible under 5 U.S.C. 8906a is not sufficient to pay the withholdings for the plan in which the employee is enrolled, the employing office shall notify the employee of the plans available at a cost that does not exceed the employee's salary. The employee may enroll in another plan whose cost is no greater than his or her salary within 60 days after receiving such notification from the employing office. The change of enrollment takes effect immediately upon termination of the prior enrollment.

(m) *An employee or eligible family member becomes eligible for premium assistance under Medicaid or a State Children's Health Insurance Program (CHIP).* An eligible employee may enroll and an enrolled employee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the employee or an eligible family member of the employee becomes eligible for premium assistance under a Medicaid plan or CHIP. An employee must enroll or change his or her enrollment within 60 days after the date the employee or family member is determined to be eligible for assistance.

(n) OPM will annually determine the lowest-cost nationwide plan option calculated based on the enrollee share of the cost of a self only enrollment. The plan option identified may not be a High Deductible Health Plan (HDHP) or an option from a health benefits plan that charges an association or membership fee. OPM reserves the right to designate an alternate plan for automatic enrollments if OPM determines circumstances dictate this.

[62 FR 38435, July 18, 1997; 62 FR 49557, Sept. 22, 1997, as amended at 65 FR 44646, July 19, 2000; 68 FR 56524, Oct. 1, 2003; 69 FR 56928, Sept. 23, 2004; 72 FR 1912, Jan. 17, 2007; 75 FR 76616, Dec. 9, 2010; 79 FR 62329, Oct. 17, 2014; 80 FR 55734, Sept. 17, 2015; 80 FR 65882, Oct. 28, 2015]

### § 890.302 Coverage of family members.

(a)(1) *Enrollment.* An enrollment for self plus one includes the enrollee and one eligible family member. An enrollment for self and family includes all family members who are eligible to be covered by the enrollment except as provided in § 890.308(h). Proof of family member eligibility may be required, and must be provided upon request, to the carrier, the employing office or OPM. Except as provided in paragraph (a)(2) of this section, no employee, former employee, annuitant, child, or former spouse may enroll or be covered as a family member if he or she is already covered under another person's self plus one or self and family enrollment in the FEHB Program.

(2) *Dual enrollment.* (i) A dual enrollment exists when an individual is covered under more than one FEHB Program enrollment. Dual enrollments are prohibited except when an eligible individual would otherwise not have access to coverage and the dual enrollment has been authorized by the employing office.

(ii) *Exception.* An individual described in paragraph (a)(2)(i) of this section may enroll if he or she or his or her eligible family members would otherwise not have access to coverage, in which case the individual may enroll in his or her own right for self only, self plus one, or self and family coverage, as appropriate. However, an eligible individual is entitled to receive benefits under only one enrollment regardless of whether he or she qualifies as a family member under a spouse's or parent's enrollment. To ensure that no person receives benefits under more

than one enrollment, each enrollee must promptly notify the insurance carrier as to which person(s) will be covered under his or her enrollment. These individuals are not covered under the other enrollment. Examples include but are not limited to:

(A) To protect the interests of married or legally separated Federal employees, annuitants, and their children, an employee or annuitant may enroll in his or her own right in a self only, self plus one, or self and family enrollment, as appropriate, even though his or her spouse also has a self plus one or self and family enrollment if the employee, annuitant, or his or her children live apart from the spouse and would otherwise not have access to coverage due to a service area restriction and the spouse refuses to change health plans.

(B) When an employee who is under age 26 and covered under a parent's self plus one or self and family enrollment acquires an eligible family member, the employee may elect to enroll for self plus one or self and family coverage.

(iii) Children are entitled to receive benefits under only one enrollment regardless of whether the children qualify as family members under the enrollment of both parents or of a parent and a stepparent and regardless of whether the parents are married, unmarried, divorced, or legally separated. To ensure that no person receives benefits under more than one enrollment, each enrollee must promptly notify the insurance carrier as to which family members will be covered under his or her enrollment. These individuals are not covered under the other enrollment.

(b)(1) A child under the age of 26, or a child of any age who is incapable of self-support because of a mental or physical disability which existed before age 26, is considered to be a family member eligible to be covered by the enrollment of an enrolled employee or annuitant or a former employee or child enrolled under §890.1103 of this part if he or she is—

(i) A child born within marriage;

(ii) A recognized natural child;

(iii) An adopted child;

(iv) A stepchild; or

(v) A foster child.

(2) For purposes of this part, the term ''stepchild'' refers to the child of an enrollee's spouse and shall continue to refer to such child after the enrollee's divorce from the spouse or death of the spouse, so long as the child continues to live with the enrollee in a regular parent-child relationship.

(c) *Child incapable of self-support.* When an individual's enrollment for self plus one or self and family includes a child who has become 26 years of age and is incapable of self-support, the employing office must require such enrollee to submit a physician's certificate verifying the child's disability. The certificate must—

(1) State that the child is incapable of self-support because of a physical or mental disability that existed before the child became 26 years of age and that can be expected to continue for more than 1 year;

(2) Include a statement of the name of the child, the nature of the disability, the period of time it has existed, and its probable future course and duration; and,

(3) Be signed by the physician and show the physician's office address. The employing office must require the enrollee to submit the certificate on or before the date the child becomes 26 years of age. However, the employing office may accept otherwise satisfactory evidence of incapacity that is not timely filed.

(d) *Renewal of certificates of incapacity.* The employing office must require an enrollee who has submitted a certificate of incapacity to renew that certificate on the expiration of the minimum period of disability certified.

(e) *Determination of incapacity.* (1) Except as provided in paragraph (e)(2) of this section, the employing office shall make determinations of incapacity.

(2) Either the employing office or the carrier may make a determination of incapacity if a medical condition, as specified by OPM, exists that would cause a child to be incapable of self-support during adulthood.

(f) *Switching a covered family member.* (1) An enrollee with a self plus one enrollment may switch his or her covered family member during the annual Open

Season, upon a change in family status, upon a change in coverage, or upon a change in eligibility, so long as switching a covered family member is consistent with the event that has taken place.

(2) Switching a covered family member under a self plus one enrollment will be effective on the first day of the first pay period that begins after the date the employing office receives an appropriate request to switch the covered family member.

[78 FR 64876, Oct. 30, 2013, as amended at 80 FR 55735, Sept. 17, 2015; 81 FR 86906, Dec. 2, 2016; 83 FR 3061, Jan. 23, 2018; 83 FR 32192, July 12, 2018]

### § 890.303 Continuation of enrollment.

(a) *On transfer or retirement.* (1) Except as otherwise provided by this part, the enrollment of an employee or annuitant eligible to continue enrollment continues without change when he or she moves from one employing office to another, without a break in service of more than 3 days, whether the personnel action is designated as a transfer or not.

(2) In order for an employee to continue an enrollment as an annuitant, he or she must meet the participation requirements set forth at 8905(b) of title 5, United States Code, for continuing an enrollment as an annuitant as of the commencing date of his or her annuity or monthly compensation.

(3) For the purpose of this part, an employee is considered to have enrolled at his or her first opportunity if the employee enrolled during the first of the periods set forth in § 890.301 in which he or she was eligible to enroll or was covered at that time by the enrollment of another employee or annuitant, or whose enrollment was effective not later than December 31, 1964.

(4) Enrollment or eligibility for enrollment under subparts H or K of this part of an individual who is not an employee eligible for coverage under other provisions of this part is not considered in determining whether a retiring employee has met the participation requirements of § 8905(b) of title 5, U.S. Code. Coverage under subparts H or K of this part of an individual who is an employee eligible for coverage under other provisions of this part may be considered in determining whether a retiring employee has met the participation requirements.

(b) *Change of enrolled employees to certain excluded positions.* Employees and annuitants enrolled under this part who move, without a break in service or after a separation of 3 days or less, to an employment in which they are excluded by § 890.102(c), continue to be enrolled unless excluded by paragraphs (c)(4), (5), (6), (7), or (9) of § 890.102.

(c) *On death.* The enrollment of a deceased employee or annuitant who is enrolled for self plus one or self and family (as opposed to self only) is transferred automatically to his or her eligible survivor annuitant(s) covered by the enrollment, as applicable. For self and family, the enrollment is considered to be that of:

(1) The survivor annuitant from whose annuity all or the greatest portion of the withholding for health benefits is made; or

(2) The surviving spouse entitled to a basic employee death benefit. The enrollment covers members of the family of the deceased employee or annuitant. In those instances in which the annuity is split among surviving family members, multiple enrollments are allowed. A remarried spouse is not a member of the family of the deceased employee or annuitant unless annuity under section 8341 or 8442 of title 5, United States Code, continues after remarriage.

(d)(1) *Survivor annuitants.* If an employee who is entitled to health benefits coverage as a survivor annuitant elects to enroll or to continue to be enrolled under his eligibility as an employee, and is thereafter separated without entitlement to continued enrollment based on his own service, he is entitled to reinstatement of his employee-acquired enrollment on application to his retirement office. Reinstatement is effective immediately after termination of his employee-acquired enrollment if the application is received by the retirement office within 60 days of separation; otherwise reinstatement is effective on the first day of the first pay period after receipt of the application. The retirement office shall withhold from the annuity that the former employee receives as a

survivor annuitant, the amounts necessary to pay his share of the cost of the enrollment.

(2) *Employee becomes a survivor annuitant.* (i) If an employee who is entitled to health benefits coverage as a survivor annuitant elects to enroll or to continue to be enrolled under his or her eligibility as an employee, and is thereafter separated without entitlement to continued enrollment based on his or her own service, the employee is entitled to reinstatement of the enrollment as a survivor annuitant on application to the retirement office. Reinstatement as a survivor annuitant is effective on the day after the termination date of the employee-acquired enrollment if the application is received by the retirement office within 60 days of separation; otherwise, reinstatement is effective on the first day of the first pay period after receipt of the application. The retirement office shall withhold from the annuity that the former employee receives as a survivor annuitant the amounts necessary to pay the health benefits premium.

(ii) If the surviving spouse of a deceased employee or annuitant is enrolled as an employee with a self plus one or self and family enrollment (or, if both the decedent and the surviving spouse were enrolled in a self only or self plus one enrollment) at the time the surviving spouse becomes a survivor annuitant and the surviving spouse is thereafter separated without entitlement to continued enrollment as a retiree, the surviving spouse is entitled to enroll as a survivor annuitant. The change from coverage as an employee to coverage as a survivor annuitant must be made within 30 days of separation from service.

(iii) Except for an employee who meets the definition of former spouse under 5 U.S.C. 8901(10) based on an individual's deferred annuity under 5 U.S.C. 8341(h) or 8445(f), the employee survivor of an annuitant receiving deferred retirement benefits is not eligible for FEHB Program enrollment as a survivor annuitant and therefore may not enroll as a survivor annuitant based on coverage obtained as an employee.

(3) *Insurable interest survivor annuity.* A current spouse who is an insurable interest beneficiary under § 831.606(b) or § 842.605(b) of this title is eligible to continue health benefits enrollment as an insurable interest survivor annuitant so long as he or she was covered as a family member at the time of the annuitant's death. This entitlement applies even if the spouse is eligible for continued enrollment as a survivor annuitant under another section of 5 CFR parts 831 or 843. To prevent dual coverage, the spouse must be covered under only one health benefits enrollment under this part.

(e) *In nonpay status.* (1) Except as otherwise provided by law, the enrollment of an employee continues while he/she is in nonpay status for up to 365 days. The 365 days' nonpay status may be continuous or broken by periods of less than 4 consecutive months in pay status. If an employee has at least 4 consecutive months in pay status after a period of nonpay status he/she is entitled to begin the 365 days' continuation of enrollment anew. For the purposes of this paragraph, 4 consecutive months in pay status means any 4-month period during which the employee is in pay status for at least part of each pay period.

(2) However, in the case of an employee who is employed under an OPM approved career-related work-study program under Schedule D of at least one year's duration and who is expected to be in a pay status during not less than one-third of the total period of time from the date of the first appointment to the completion of the work-study program, his/her enrollment continues while he/she is in nonpay status so long as he/she is participating in the work-study program.

(f) [Reserved]

(g) *Former spouse entitled to coverage as employee or member of family.* An individual entitled to health benefits as a former spouse who also has or becomes entitled to health benefits coverage as a Federal employee or as a family member under another enrollment under this part may defer or suspend coverage as a former spouse and continue his or her coverage as an employee or family member. The former spouse must have established entitlement to the health benefits coverage under § 890.803 of this part and filed all

required documents with the employing office responsible for maintaining the former spouse enrollment within the time limits specified in § 890.805 of this part. The employing office shall note in the former spouse's file that the former spouse health benefits enrollment is being deferred or suspended until coverage as a Federal employee or as a family member ends. Upon loss of coverage as a Federal employee or as a family member, the individual is entitled to enroll or resume the enrollment as a former spouse, provided he or she remains eligible as such. A former spouse who enrolls because he or she lost coverage under another enrollment under this part for a reason other than cancellation must meet the requirements of § 890.301(g)(2). A former spouse who enrolls because he or she lost coverage under another enrollment under this part as a result of cancellation of the covering enrollment must meet the requirements of § 890.301(g)(4).

(h) *Temporary continuation of coverage.* Certain former employees who lose coverage because of a separation from Federal service, certain children who lose coverage because they cease to meet the requirements for coverage as children, and certain former spouses who lose coverage because their marriage to the enrollee ends and who are not eligible for coverage under subpart H of this part may elect temporary continuation of coverage under the provisions of subpart K of this part.

(i) *Service in the uniformed services.* (1) The enrollment of an individual who separates, enters military furlough, or is placed in nonpay status to serve in the uniformed services under conditions that entitle him or her to benefits under part 353 of this chapter, or similar authority, may continue for the 24-month period beginning on the date that the employee is placed on leave without pay or separated from service to perform active duty in the uniformed services, provided that the individual continues to be entitled to benefits under part 353 of this chapter, or similar authority. As provided for by 5 U.S.C. 8905(a), the continuation of enrollment for up to 24 months applies to employees called or ordered to active duty in support of a contingency operation on or after September 14, 2001. The enrollment of an employee who met the requirements of chapter 43 of title 38, United States Code, on or after December 10, 2004, may continue for the 24-month period beginning on the date that the employee is placed on leave without pay or separated from service to perform active duty in the uniformed services, provided that the employee continues to be entitled to continued coverage under part 353 of this chapter, or similar authority.

(2) An employee in nonpay status is entitled to continued coverage under paragraph (e) of this section if the employee's entitlement to benefits under part 353 of this chapter, or similar authority, ends before the expiration of 365 days in nonpay status.

(3) If the enrollment of an employee had terminated due to the expiration of 365 days in nonpay status or because of the employee's separation from service, it may be reinstated for the remainder of the 24-month period beginning on the date that the employee is placed on leave without pay or separated from service to perform active duty in the uniformed services, provided that the employee continues to be entitled to continued coverage under part 353 of this chapter, or similar authority.

[33 FR 12510, Sept. 4, 1968]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 890.303, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

### § 890.304 Termination of enrollment.

(a) *Employees.* (1) An employee's enrollment terminates, subject to the temporary extension of coverage for conversion, at midnight of the earliest of the following dates:

(i) The last day of the pay period in which he/she is separated from the service other than by retirement under conditions entitling him/her to continue his/her enrollment.

(ii) The last day of the pay period in which he or she separates after meeting the requirements for an immediate annuity under § 842.204(a)(1) of this chapter, but postpones receipt of annuity as provided by § 842.204(c).

(iii) The last day of the pay period in which his or her employment status or

the eligibility of his or her position changes so that he or she is excluded from enrollment.

(iv) The last day of the pay period in which he dies, unless he leaves a member of the family entitled to continue enrollment as a survivor annuitant.

(v) The last day of the pay period which includes the day on which the continuation of enrollment under §890.303(e) expires, or, if he/she is not entitled to any further continuation because he/she has not had 4 consecutive months of pay status since exhausting his/her 365 days' continuation of coverage in nonpay status, the last day of his/her last pay period in pay status.

(vi) The day he or she is separated, furloughed, or placed on leave of absence to serve in the uniformed services under conditions entitling him or her to benefits under part 353 of this chapter, or similar authority, for the purpose of performing duty not limited to 30 days or less, provided the employee elects in writing to have the enrollment so terminated.

(vii) For an employee who separates to serve in the uniformed services under conditions entitling him or her to benefits under part 353 of this chapter, or similar authority, for the purpose of performing duty not limited to 30 days or less, the date that is 24 months after the date that the employee is placed on leave without pay or separated from service to perform active duty in the uniformed services, or the date entitlement to benefits under part 353 of this chapter, or similar authority, ends, whichever is earlier, unless the enrollment is terminated under paragraph (a)(1)(vi) of this section.

(viii) For an employee who is furloughed or placed on leave of absence under conditions entitling him or her to benefits under part 353 of this chapter, or similar authority, the date that is 24 months after the date that the employee is placed on leave without pay or separated from service to perform active duty to serve in the uniformed services, or the date entitlement to benefits under part 353 of this chapter, or similar authority, ends, whichever is earlier, but not earlier than the date the enrollment would otherwise terminate under paragraph (a)(1)(v) of this section.

(2) If the pay of a temporary employee eligible under 5 U.S.C. 8906a is insufficient to pay the withholdings for the plan in which the employee is enrolled, and the employee does not, or cannot, elect a plan under §890.301(l) at a cost to him or her not in excess of the pay, the employing office must terminate the employee's enrollment effective as of the end of the last period for which withholding was made. Each temporary employee whose enrollment is so terminated is entitled to a 31-day extension of coverage for conversion.

(b) *Annuitants.* (1) If the annuity of an annuitant is insufficient to pay the withholdings for the plan in which the annuitant is enrolled, the annuitant may elect one of the two opportunities offered under §890.306(q) of this part (electing a plan with a withholding not in excess of the annuity; or, paying premiums directly to the retirement system in accordance with §890.502(f) of this part). The retirement system will send two notices to the annuitant, including one by certified mail return receipt requested. Continuation of coverage rests upon electing direct payment or new coverage within 15 days (45 days for annuitants residing overseas) after receipt of the final notice. Except as provided in paragraph (b)(3) of this section, the enrollment of an individual who fails to make an election within the specified time frame will be terminated. An annuitant whose enrollment is terminated because of failure to make an election may not reenroll or reinstate coverage, except as provided in paragraph (b)(2) of this section. Each annuitant whose enrollment is so terminated is entitled to a 31-day extension of coverage for conversion.

(2) If the individual was prevented by circumstances beyond his or her control from making an election within the time limit after receipt of the final notice, he or she may request reinstatement of coverage by writing to the retirement system. The retirement system will determine if the individual is eligible for reinstatement of coverage; and, when the determination is affirmative, the individual's coverage may be reinstated retroactively to the date of termination or prospectively. If

the determination is negative, the individual may request reconsideration of the decision from OPM.

(3) If the annuitant does not make an election under paragraph (b)(1) of this section and is enrolled in the high option of a plan that has two options, the annuitant is deemed to have elected enrollment in the standard option of the same plan unless the annuity is insufficient to pay the withholdings for the standard option.

(4) An annuitant's enrollment terminates, subject to the temporary extension of coverage for conversion, at midnight of the last day of the pay period in which he dies, unless he leaves a member of the family entitled to continue enrollment as a survivor annuitant, or, if his enrollment is not terminated by death, at midnight of the earliest of the following dates:

(i) The last day of the last pay period for which he is entitled to annuity, unless he is eligible for continued enrollment as an employee in which case his enrollment continues without change.

(ii) The last day of the pay period in which his title to compensation under subchapter I of chapter 81 of title 5, United States Code, terminates, or in which he is held by the Secretary of Labor to be able to return to duty, unless he is eligible for continued enrollment as an employee or as an annuitant under a retirement system for civilian employees in which case his enrollment continues without change.

(iii) The day he enters on active duty in a uniformed service for the purpose of performing duty not limited to 30 days or less, provided the annuitant elects, in writing, to terminate the enrollment.

(iv) The last day of the month preceding the month in which a survivor annuitant in receipt of basic employee death benefits under 5 U.S.C. 8442(b)(1)(A) remarries before attaining age 55.

(c) *Coverage of family members.* The coverage of a family member of an enrollee terminates, subject to the temporary extension of coverage for conversion, at midnight of the earlier of the following dates:

(1) The day on which he or she ceases to be a family member;

(2) The day the enrollee ceases to be enrolled, unless the family member is entitled, as a survivor annuitant, to continued enrollment, or is entitled to continued coverage under the enrollment of another.

(d) *Cancellation or suspension.* (1)(i) An employee who participates in health insurance premium conversion as provided in part 892 of this chapter may cancel his or her enrollment only during an open season or because of and consistent with a qualifying life event defined in § 892.101 of this chapter.

(ii) Subject to the provisions of paragraph (d)(iii) of this section, an enrollee who does not participate in premium conversion may cancel his or her enrollment at any time by filing an appropriate request with the employing office. The cancellation is effective at the end of the last day of the pay period in which the employing office receives the appropriate request canceling the enrollment.

(iii) An employee who is subject to a court or administrative order as discussed in § 890.301(g)(3), or an annuitant who was subject to such a court or administrative order at the time of his or her retirement, may not cancel or suspend his or her enrollment as long as the court or administrative order is still in effect and the enrollee has at least one child identified in the order who is still eligible under the FEHB Program, unless the employee or annuitant provides documentation to the agency that he or she has other coverage for the child or children.

(2) An annuitant or survivor annuitant may suspend enrollment in FEHB for the purpose of enrolling in a Medicare-sponsored plan under sections 1833, 1876, or 1851 of the Social Security Act, or to enroll in the Medicaid program or a similar State-sponsored program of medical assistance for the needy, or to use Peace Corps or CHAMPVA or TRICARE (including coverage provided by the Uniformed Services Family Health Plan) or TRICARE-for-Life instead of FEHB coverage. To suspend FEHB coverage, documentation of eligibility for coverage under the non-FEHB program must be submitted to the retirement system. If the documentation is received within the period beginning 31

days before and ending 31 days after the effective date of the enrollment in the Medicare-sponsored plan, or the Medicaid or similar program, or within 31 days before or after the day designated by the annuitant or survivor annuitant as the day he or she wants to suspend FEHB coverage to use Peace Corps or CHAMPVA or TRICARE (including the Uniformed Services Family Health Plan) or TRICARE-for-Life instead of FEHB coverage, then suspension will be effective at the end of the day before the effective date of the enrollment or the end of the day before the day designated. Otherwise, the suspension is effective the first day of the first pay period that begins after the date the retirement system receives the documentation.

(3) The enrollee and covered family members are not entitled to the temporary extension of coverage for conversion or to convert to an individual contract for health benefits.

(e) *Temporary continuation of coverage.* Employees and family members are entitled to temporary continuation of coverage only as provided under subpart K of this part.

[33 FR 12510, Sept. 4, 1968]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 890.304, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

### § 890.305 Reinstatement of enrollment after military service.

(a) The enrollment of an employee or annuitant whose enrollment was terminated under § 890.304(a)(1)(vi), (vii), or (viii) or § 890.304(b)(4)(iii) is automatically reinstated on the day the employee is restored to a civilian position under the provisions of part 353 of this chapter, or similar authority, or on the day the annuitant is separated from the uniformed services, as the case may be.

(b) An employee whose employing office terminates his or her enrollment because his or her order to enter on duty in a uniformed service is for a period longer than 30 days, and who retires on an immediate annuity from his or her Federal civilian position while on such duty, may reinstate his or her enrollment by asking to do so within 60 days after retirement. In the absence of such a request, the retirement system automatically reinstates the enrollment on the day the person separates from the uniformed service. For the retirement system to reinstate the enrollment, the individual must have been covered under this part since his or her first opportunity or for the 5 years of civilian service (excluding the period of uniformed service) immediately preceding the civilian retirement, whichever is shorter.

[43 FR 52460, Nov. 13, 1978, as amended at 59 FR 60296, Nov. 23, 1994; 60 FR 45658, Sept. 1, 1995; 64 FR 31488, June 11, 1999]

### § 890.306 When can annuitants or survivor annuitants change enrollment or reenroll and what are the effective dates?

(a) *Requirements to continue coverage.* (1) To be eligible to continue coverage in a plan under this part, a former employee in receipt of an annuity must meet the statutory requirements under 5 U.S.C. 8905(b) of having retired on an immediate annuity and having been covered by a plan under this part for the 5 years of service immediately before retirement, or if less than 5 years, for all service since his or her first opportunity to enroll, unless OPM waives the requirement under § 890.108.

(2) To be eligible to continue coverage in a plan under this part, a survivor annuitant must be covered as a family member when the employee or annuitant dies.

(b) *Effective date—generally.* Except as otherwise provided, an annuitant's change of enrollment takes effect on the first day of the first pay period that begins after the date the employing office receives an appropriate request to change the enrollment.

(c) *Belated enrollment.* When an employing office determines that an annuitant was unable, for cause beyond his or her control, to continue coverage by enrolling in his or her own name or change the enrollment within the time limits prescribed by this section, the annuitant may do so within 60 days after the employing office advises the annuitant of its determination.

(d) *Enrollment by proxy.* Subject to the discretion of the employing office, an annuitant's representative, having

written authorization to do so, may continue the annuitant's coverage by enrolling in the annuitant's own name, or change the enrollment for the annuitant.

(e) *Decreasing enrollment type.* (1) With one exception, an annuitant may decrease enrollment type at any time. Exception: An annuitant who, as an employee, was subject to a court or administrative order as discussed in § 890.301(g)(3) at the time he or she retired may not, after retirement, decrease enrollment type in a way that eliminates coverage of a child identified in the order as long as the court or administrative order is still in effect and the annuitant has at least one child identified in the order who is still eligible under the FEHB Program, unless the annuitant provides documentation to the retirement system that he or she has other coverage for the child or children. The annuitant may not elect self only as long as he or she has one child identified as covered, but may elect self plus one.

(2) A decrease in enrollment type takes effect on the first day of the first pay period that begins after the date the employing office receives an appropriate request to change the enrollment, except that at the request of the annuitant and upon a showing satisfactory to the employing office that there was no family member eligible for coverage under the self plus one or self and family enrollment, or only one family member eligible for coverage under the self and family enrollment, as appropriate, the employing office may make the change effective on the first day of the pay period following the one in which there was, in the case of a self plus one enrollment, no family member or, in the case of a self and family enrollment, only one or no family member.

(f) *Open season.* (1) During an open season as provided by § 890.301(f)—

(i) With one exception, an enrolled annuitant may decrease or increase enrollment type, may change from one plan or option to another, or may make any combination of these changes. Exception: An annuitant who, as an employee, was subject to a court or administrative order as discussed in § 890.301(g)(3) at the time he or she retired may not cancel or suspend his or her enrollment, decrease enrollment type in a way that eliminates coverage of a child identified in the order or change to a comprehensive medical plan that does not serve the area where his or her child or children live after retirement as long as the court or administrative order is still in effect and the annuitant has at least one child identified in the order who is still eligible under the FEHB Program, unless the annuitant provides documentation to the retirement system that he or she has other coverage for the child or children. The annuitant may not elect self only as long as he or she has one child identified as covered, but may elect self plus one.

(ii) An annuitant or survivor annuitant who suspended enrollment under this part to enroll in a Medicare-sponsored plan under sections 1833, 1876, or 1851 of the Social Security Act, or to enroll in a Medicaid or similar State-sponsored program of medical assistance for the needy, or to use Peace Corps or CHAMPVA or TRICARE (including the Uniformed Services Family Health Plan) or TRICARE-for-Life coverage instead of FEHB coverage, may reenroll.

(2) An open season reenrollment or change of enrollment takes effect on the first day of the first pay period that begins in January of the next following year.

(3) When a belated open season reenrollment or change of enrollment is accepted by the employing office under paragraph (c) of this section, it takes effect as required by paragraph (f)(2) of this section.

(g) *Change in family status.* (1) An enrolled former employee in receipt of an annuity may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the annuitant's family status changes, including a change in marital status or any other change in family status. In the case of an enrolled survivor annuitant, a change in family status based on additional family members occurs only if the additional family members are family members of the deceased employee or annuitant. The annuitant must change the enrollment within the

period beginning 31 days before the date of the change in family status, and ending 60 days after the date of the change in family status.

(2) A change of enrollment made in conjunction with the birth of a child, or the addition of a child as a new family member in some other manner, takes effect on the first day of the pay period in which the child is born or becomes an eligible family member.

(h) *Reenrollment of annuitants or survivor annuitants who suspended enrollment to enroll in a Medicare-sponsored plan, or a Medicaid or similar State-sponsored program; or to use Peace Corps or CHAMPVA or TRICARE (including the Uniformed Services Family Health Plan) or TRICARE-for-Life coverage instead of FEHB coverage.* (1) An annuitant or survivor annuitant who had been enrolled (or was eligible to enroll) for coverage under this part and suspended the enrollment for the purpose of enrolling in a Medicare sponsored plan under sections 1833, 1876, or 1851 of the Social Security Act, or to enroll in the Medicaid program or a similar State-sponsored program of medical assistance for the needy, or to use Peace Corps or CHAMPVA or TRICARE (including the Uniformed Services Family Health Plan) or TRICARE-for-Life coverage instead of the FEHB Program (as provided by §890.304(d)), and who subsequently involuntarily loses coverage under one of these programs, may immediately reenroll in any available FEHB plan under this part at any time beginning 31 days before and ending 60 days after the loss of coverage. A reenrollment under this paragraph (h) of this section takes effect on the date following the effective date of the loss of coverage as shown on the documentation from the non-FEHB coverage. If the request to reenroll is not received by the retirement system within the time period specified, the annuitant must wait until the next available Open Season to reenroll.

(2) An annuitant or survivor annuitant who suspended enrollment in the FEHB Program to enroll in a Medicare sponsored plan or the Medicaid or similar State-sponsored program of medical assistance for the needy, or to use Peace Corps or CHAMPVA or TRICARE (including the Uniformed Services Family Health Plan) or TRICARE-for-Life, but now wants to reenroll in the FEHB Program for any reason other than an involuntary loss of coverage, may do so during the next available Open Season (as provided by paragraph (f) of this section).

(i) [Reserved]

(j) *Annuitants who apply for postponed minimum retirement age plus 10 years of service (MRA plus 10) annuity.* (1) A former employee who meets the requirements for an immediate annuity under 5 U.S.C. 8412(g) and for continuation of coverage under 5 U.S.C. 8905(b) at the time of separation, and whose enrollment is terminated under §890.304(a)(1)(ii) may enroll in a health benefits plan under this part within 60 days after OPM mails the former employee a notice of eligibility. If such former employee dies before the end of this 60-day election period, a survivor who is entitled to a survivor annuity may enroll in a health benefits plan under this part within 60 days after OPM mails the survivor a notice of eligibility.

(2) The former employee's enrollment takes effect on the first day of the month following the month in which OPM receives the appropriate request or on the commencing date of annuity, whichever is later. A survivor's enrollment takes effect on the first day of the month following the month in which OPM receives the appropriate request.

(k) *Restoration of annuity or compensation payments.* (1) A disability annuitant who was enrolled in a health benefits plan under this part immediately before his or her disability annuity was terminated because of restoration to earning capacity or recovery from disability, and whose disability annuity is restored under 5 U.S.C. 8337(e) after December 31, 1983, or 8455(b), may enroll in a health benefits plan under this part within 60 days after OPM mails a notice of insurance eligibility. The enrollment takes effect on the first day of the month after the date OPM receives the appropriate request.

(2) An annuitant who was enrolled in a health benefits plan under this part immediately before his or her compensation was terminated because OWCP determined that he or she had

recovered from the job-related injury or disease, and whose compensation is restored due to a recurrence of disability, may enroll in a health benefits plan under this part within 60 days after OWCP mails a notice of insurance eligibility. The enrollment takes effect on the first day of the pay period after the date OWCP receives the appropriate request.

(3) A surviving spouse who was covered by a health benefits enrollment under this part immediately before his or her survivor annuity was terminated because of remarriage, and whose survivor annuity is later restored, may enroll in a health benefits plan under this part within 60 days after OPM mails a notice of eligibility. The enrollment takes effect on either—

(i) The first day of the month after the date OPM receives the appropriate request; or

(ii) The date of restoration of the survivor annuity or October 1, 1976, whichever is later.

(4) A surviving child who was covered by a health benefits enrollment under this part immediately before his or her survivor annuity was terminated because he or she ceased being a student, and whose survivor annuity is later restored, may enroll in a health benefits plan under this part within 60 days after OPM mails a notice of eligibility. The enrollment takes effect on the first day of the month after the date OPM receives the appropriate request or the date of restoration of the survivor annuity, whichever is later.

(5) A surviving child who was covered by a health benefits enrollment under this part immediately before his or her survivor annuity was terminated because he or she married, and whose survivor annuity is later restored because the marriage ended, may enroll in a health benefits plan under this part within 60 days after OPM mails a notice of eligibility. The enrollment takes effect on the first day of the month after the date OPM receives the appropriate request or the date of restoration of the survivor annuity, whichever is later.

(6) A surviving spouse who received a basic employee death benefit under 5 U.S.C. 8442(b)(1)(A) and who was covered by a health benefits enrollment under this part immediately before remarriage prior to age 55, may enroll in a health benefits plan under this part upon termination of the remarriage. The survivor must provide OPM with a certified copy of the notice of death or the court order terminating the marriage. The surviving spouse must enroll within 60 days after OPM mails a notice of eligibility. The enrollment takes effect on the first day of the month after the date OPM receives the appropriate request and the notice of death or court order terminating the remarriage.

(l) *Loss of coverage under this part or under another group insurance plan.* An annuitant who meets the requirements of paragraph (a) of this section, and who is not enrolled but is covered by another enrollment under this part may continue coverage by enrolling in his or her own name when the annuitant loses coverage under the other enrollment under this part. An enrolled annuitant may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the annuitant or an eligible family member of the annuitant loses coverage under this part or under another group health benefits plan. Except as otherwise provided, an annuitant must enroll or change the enrollment within the period beginning 31 days before the date of loss of coverage and ending 60 days after the date of loss of coverage. Losses of coverage include, but are not limited to—

(1) Loss of coverage under another FEHB enrollment due to the termination, cancellation, or a change to self plus one or self only, of the covering enrollment;

(2) Loss of coverage under another federally-sponsored health benefits program;

(3) Loss of coverage due to the termination of membership in an employee organization sponsoring or underwriting an FEHB plan;

(4) Loss of coverage due to the discontinuance of an FEHB plan in whole or in part. For an annuitant who loses coverage under this paragraph (l)(4)—

(i) If the discontinuance is at the end of a contract year, the annuitant must change the enrollment during the open

season, unless OPM establishes a different time. If the discontinuance is at a time other than the end of the contract year, OPM must establish a time and effective date for the annuitant to change the enrollment;

(ii) If a plan discontinues all of its existing options, an annuitant who does not change his or her enrollment is deemed to have enrolled in the lowest-cost nationwide plan option, as defined in § 890.301(n); except when the annuity is insufficient to pay the withholdings, then paragraph (q) of this section applies.

(iii) If one or more options of a plan are discontinued, an annuitant who does not change the enrollment will be enrolled in the remaining option of the plan, or in the case of a plan with two or more options remaining, the lowest-cost remaining option that is not a High Deductible Health Plan (HDHP). In the event that the annuity is insufficient to pay the withholdings, then paragraph (q) of this section applies;

(iv) After an involuntary enrollment under paragraph (l)(4)(ii) or (iii) of this section becomes effective, the annuitant may change the enrollment to another option of the plan into which he or she was enrolled or another health plan of his or her choice prospectively within 90-days after OPM advises the annuitant of the new enrollment;

(v) If the discontinuance of the plan, whether permanent or temporary, is due to a disaster, an annuitant must change the enrollment within 60 days of the disaster, as announced by OPM. If an annuitant does not change the enrollment within the time frame announced by OPM, the annuitant will be enrolled in the lowest-cost nationwide plan option, as defined in § 890.301(n). The effective date of enrollment changes under this provision will be set by OPM when it makes the announcement allowing such changes;

(vi) An annuitant who is unable, for causes beyond his or her control, to make an enrollment change within the 60 days following a disaster and is, as a result, enrolled in the lowest-cost nationwide plan as defined in § 890.301(n), may request a belated enrollment into the plan of his or her choice subject to the requirements of paragraph (c) of this section.

(5) Loss of coverage under the Medicaid program or similar State-sponsored program of medical assistance for the needy.

(6) Loss of coverage under a non-Federal health plan.

(m) *Move from comprehensive medical plan's area.* An annuitant in a comprehensive medical plan who moves or becomes employed outside the geographic area from which the plan accepts enrollments, or, if already outside this area, moves or becomes employed further from this area, may change the enrollment upon notifying the employing office of the move or change of place of employment. Similarly, an annuitant whose covered family member moves outside the geographic area from which the plan accepts enrollments, or if already outside this area, moves further from this area, may change the enrollment upon notifying the employing office of the family member's move. The change of enrollment takes effect on the first day of the pay period that begins after the employing office receives an appropriate request.

(n) *Overseas post of duty.* An annuitant may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes within 60 days after the retirement or death of the employee on whose service title to annuity is based, if the employee was stationed at a post of duty outside a State of the United States or the District of Columbia at the time of retirement or death.

(o) *On return from a uniformed service.* An enrolled annuitant who enters on duty in a uniformed service for 31 days or more may change the enrollment within 60 days after separation from the uniformed service.

(p) *On becoming eligible for Medicare.* An annuitant may change the enrollment from one plan or option to another at any time beginning on the 30th day before becoming eligible for coverage under title XVIII of the Social Security Act (Medicare). A change of enrollment based on becoming eligible for Medicare may be made only once.

(q) *Annuity insufficient to pay withholdings.* (1) If an annuity is insufficient to pay the withholdings for the plan that the annuitant is enrolled in, the retirement system must provide the annuitant with information regarding the available plans and written notification of the opportunity to either—

(i) Pay the premium directly to the retirement system in accordance with § 890.502(d); or

(ii) Enroll in any plan in which the annuitant's share of the premium is less than the amount of annuity. If the annuitant elects to change to a lower cost enrollment, the change takes effect immediately upon loss of coverage under the prior enrollment. The exemptions from debt collection procedures that are provided under § 831.1305(d)(2) and § 845.205(d)(2) of this chapter apply to elections under this paragraph (q)(1)(ii).

(2) If the annuitant is enrolled in the high option of a plan that has two options, and does not change the enrollment to a plan in which the annuitant's share of the premium is less than the amount of annuity or does not elect to pay premiums directly, the annuitant is deemed to have enrolled in the standard option of the same plan, unless the annuity is insufficient to pay the withholdings for the standard option.

(3) An annuitant whose enrollment was terminated because the amount of annuity was insufficient to cover the enrollee's share of the premium may apply to be reinstated in any available plan or option.

(4) An annuitant who can show evidence that he or she previously changed to a lower cost option, plan, or to a self-only enrollment prior to May 29, 1990, because the annuity was insufficient to cover the withholdings for the plan in which he or she was enrolled, may apply to change the enrollment to any available plan or option in which the enrollee's share of the total premium exceeds his or her monthly annuity.

(5) The effective date of the reinstatement of enrollment of an annuitant whose enrollment was terminated, or the change of enrollment of an annuitant who previously changed enrollment because his or her annuity was insufficient to cover the annuitant's share of the total premium, and who elects to pay premiums directly to the retirement system in accordance with § 890.502(f) is either—

(i) The first day of the first pay period that begins after the appropriate request is received by the retirement system; or,

(ii) The later of the date the enrollment was terminated or changed, or May 29, 1990.

(6) Retroactive reinstatement or change of enrollment is contingent upon payment of appropriate contributions retroactive to the effective date of the reinstatement or the change of enrollment. For the purpose of this paragraph (q)(6), a previous cancellation of enrollment because of insufficient annuity to cover the full amount of the withholdings is deemed to be a termination of enrollment.

(r) *Sole survivor.* When an employee or annuitant enrolled for self plus one or self and family dies, leaving a survivor annuitant who is entitled to continue the enrollment, and it is apparent from available records that the survivor annuitant is the sole survivor entitled to continue the enrollment, the office of the retirement system which is acting as employing office must decrease the enrollment to self only, effective on the commencing date of the survivor annuity. On request of the survivor annuitant made within 31 days after the first installment of annuity is paid, the office of the retirement system which is acting as employing office must rescind the action retroactive to the effective date of the change to self only, with corresponding adjustment in withholdings and contributions.

(s) *Election between survivor annuities.* A surviving spouse, irrespective of whether his or her survivor annuity continued or was terminated upon remarriage, who was covered by an enrollment under this part immediately before the remarriage, may elect to continue an enrollment under this part acquired as a dependent by virtue of the remarriage or to enroll in his or her own right (by virtue of entitlement to the original survivor annuity) in any plan or option under this part within 60 days after the termination of

the remarriage and entitlement to a survivor annuity.

[62 FR 38437, July 18, 1997, as amended at 66 FR 49086, Sept. 26, 2001; 67 FR 41306, June 18, 2002; 68 FR 56525, Oct. 1, 2003; 69 FR 31722, June 7, 2004; 69 FR 56928, Sept. 23, 2004; 70 FR 33798, June 10, 2005; 70 FR 71749, Nov. 30, 2005; 72 FR 1912, Jan. 17, 2007; 80 FR 55735, Sept. 17, 2015; 80 FR 65882, Oct. 28, 2015]

### § 890.307 Waiver or suspension of annuity or compensation.

(a) Except as provided in paragraphs (b) and (f) of this section, when annuity or compensation is entirely waived or suspended, the annuitant's enrollment continues for not more than 3 months (not more than 12 weeks for annuitants whose compensation under subchapter I of chapter 81 of title 5, United States Code, is paid each 4 weeks). If the waiver or suspension continues beyond this period, the employing office will notify the annuitant in writing that the employing office will terminate the enrollment effective at the end of the period, subject to the temporary extension of coverage for conversion, unless the annuitant elects to make payment of the premium directly to the employing office during the period of waiver. If the annuitant elects to have the enrollment terminated, the employing office automatically reinstates the enrollment on a prospective basis when the annuitant again receives payment of annuity or compensation. The employing office will make the withholding for the period of waiver or suspension during which enrollment was continued (i.e., 3 months or less).

(b) If the annuitant elects to pay premiums directly, he or she must send to the employing office his or her share of the subscription charge for the enrollment for every pay period during which the enrollment continues, exclusive of the 31-day temporary extension of coverage for conversion provided in § 890.401. The annuitant must pay after each pay period he or she is covered in accordance with a schedule established by the employing office. If the employing office does not receive payment by the date due, the employing office must notify the annuitant in writing that continuation of coverage depends upon payment being made within 15 days (45 days for annuitants residing overseas) after receipt of the notice. If no further payments are made, the employing office terminates the enrollment 60 days after the date of the notice (90 days for annuitants residing overseas). The employing office automatically reinstates enrollment on a prospective basis when payment of annuity or compensation resumes.

(c) If the annuitant is prevented by circumstances beyond his or her control from paying within 15 days after receipt of the notice, he or she may request reinstatement of coverage by writing to the employing office. The annuitant must file the request within 30 calendar days from the date of termination, and must include supporting documentation. The employing office will determine if the annuitant is eligible for reinstatement of coverage; and, when the determination is affirmative, reinstate the coverage of the annuitant retroactive to the date of termination. If the determination is negative, the annuitant may request a review of the decision as provided in § 890.104.

(d) Termination of enrollment for failure to pay premiums within the time frame established in accordance with paragraph (b) of this section is retroactive to the end of the last pay period for which the employing office timely received payment.

(e) The employing office will submit all direct premium payments along with its regular health benefits premiums to OPM in accordance with procedures established by OPM.

(f) If suspension of annuity or compensation is because of reemployment, the reemploying office must make the withholding currently and enrollment continues during reemployment.

[59 FR 60296, Nov. 23, 1994, as amended at 59 FR 67607, Dec. 30, 1994]

### § 890.308 Disenrollment and removal from enrollment.

(a) *Carrier disenrollment: Enrollment reconciliation.* (1) Except as otherwise provided in this section, a carrier that cannot reconcile its record of an individual's enrollment with agency enrollment records or does not receive documentation necessary to resolve the discrepancy from the employing office within 31 days of a request must provide written notice to the individual

that the employing office of record does not show him or her as enrolled in the carrier's plan and that he or she will be disenrolled 31 calendar days after the date of the notice unless the enrollee provides appropriate documentation to resolve the discrepancy. Appropriate documentation includes, but is not limited to, a copy of the Standard Form 2809 (basic enrollment document) (or a letter confirming an electronic transaction), the Standard Form 2810 transferring the enrollment into the gaining employing office (or the equivalent electronic submission), copies of earnings and leave statements or annuity statements showing withholdings for the health benefits plan, or a document or other credible information from the enrollee's employing office stating that the individual is entitled to continued enrollment in the plan and that the premiums are being paid. After receiving documentation from the enrollee, the carrier must notify both the enrollee and the employing office of record of their decision on the information.

(2) If the carrier does not receive documentation required under paragraph (a)(1) of this section within the specified time frame, the carrier should disenroll the individual, without further notice.

(3) The enrollee may request his or her employing office to reconsider the carrier's decision to disenroll the individual. The request for reconsideration must be made in writing and must include the enrollee's name, address, Social Security Number or other personal identification number, name of carrier, reason(s) for the request, and, if applicable, retirement claim number. The employing office must notify the carrier when a request for reconsideration of the decision to disenroll the individual is made.

(4) A request for reconsideration of the carrier's decision must be filed within 60 calendar days after the date of the carrier's disenrollment notice. The time limit on filing may be extended when the individual shows that he or she was not notified of the time limit and was not otherwise aware of it, or that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(5) After reconsideration, the employing office must issue a written notice of its final decision to the individual and notify the carrier of the decision. The notice must fully set forth the findings and conclusions on which the decision was based. If upon reconsideration the employing office determines the individual is entitled to continued enrollment in the plan, the disenrollment under paragraph (a)(2) of this section is void and coverage is reinstated retroactively.

(6) If, at any time after the disenrollment has occurred, the employing office or OPM determines that another section of this part applies to the individual's enrollment or the carrier discovers or receives appropriate documentation showing that another section of this part applies to the individual's enrollment, the disenrollment under paragraph (a)(2) of this section is void and coverage is reinstated retroactively.

(b) *Carrier disenrollment: Death of enrollee.* When a carrier receives, from any reliable source, information of the death of an enrollee with a self only enrollment, the carrier may take action to disenroll the individual on the date set forth in § 890.304(a)(1)(iv) or § 890.304(b)(4), as appropriate. When the date of death is unknown, the carrier may take action to disenroll the individual on the date which is the last day of the pay period in which information of the death is received. Reliable sources include, but are not limited to, claims for hospital or physician costs incurred at time of death and correspondence returned from the Postal Service noting that the addressee is deceased. If, at any time after the disenrollment has occurred, the employing office or OPM determines that another section of this part applies to the individual's enrollment or the carrier discovers or receives appropriate documentation showing that another section of this part applies to the individual's enrollment, the disenrollment under this paragraph (b) is void and coverage is reinstated retroactively.

(c) *Carrier disenrollment: Child survivor annuitant.* (1) When a child survivor annuitant covered under a self only enrollment reaches age 22, the carrier may take action to disenroll the individual effective with the date set forth in § 890.304(c)(1) unless records with the carrier indicate that the child is incapable of self support due to a physical or mental disability. The carrier must provide the enrollee with a written notice of disenrollment prescribed or approved by OPM prior to the date set forth in § 890.304(c)(1).

(2) The child survivor annuitant may request the retirement system to reconsider the carrier's decision to disenroll the individual. The request for reconsideration must be made in writing and include the enrollee's name, address, Social Security Number or other identifier, name of carrier, reason(s) for the request, and the survivor annuity claim number. The retirement system must notify the carrier when a request for reconsideration of the carrier's decision to disenroll the individual is made.

(3) A request for reconsideration of the carrier's decision must be filed with the retirement system within 60 calendar days from the date of the carrier's disenrollment notice. The time limit on filing may be extended when the individual shows that he or she was not notified of the time limit and was not otherwise aware of it, or that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(4) After reconsideration, the retirement system must issue a written notice of its final decision to the child survivor annuitant and notify the carrier of the decision. The notice must fully set forth the findings and conclusions on which the decision was based. If upon reconsideration the retirement system determines that he or she is entitled to continued enrollment in the plan, the disenrollment under paragraph (c)(1) of this section is void and coverage is reinstated retroactively.

(5) If, at any time after the disenrollment has occurred, the employing office or OPM determines that another provision of this part applies to the individual's enrollment or the carrier discovers or receives appropriate documentation showing that another section of this part applies to the individual's enrollment, the disenrollment under paragraph (c)(1) of this section is void and coverage is reinstated retroactively.

(d) *Carrier disenrollment: Separation from Federal employment.* When an enrollee notifies the carrier that he or she has separated from Federal employment and is no longer eligible for enrollment, the carrier must disenroll the individual on the last day of the pay period in which the separation occurred, if known, otherwise the carrier must disenroll the employee on the date the employee provides as the date of separation. The carrier must provide the enrollee with a written notice of disenrollment prescribed or approved by OPM.

(e) *Carrier removal from enrollment: Ineligible individuals.* (1) A carrier may request verification of eligibility from the enrollee at any time of an individual who is covered as a family member of the enrollee in accordance with § 890.302. To verify eligibility, the carrier shall send the enrollee a request for appropriate documentation of the individual's relationship to the enrollee with a copy to the enrollee's employing office of record. The request shall contain a written notice that the individual will no longer be covered 60 calendar days after the date of the notice unless the enrollee or the employing office provides appropriate documentation as requested. If the carrier does not receive the requested documentation within the specified time frame or if based on the documentation provided the individual is found not to be eligible, the carrier shall remove the individual from the enrollment and shall provide written notice of removal to the enrollee, with a copy to the employing office, including an explanation of the process for seeking reconsideration. The carrier may extend the time limit to provide appropriate documentation if the enrollee or the removed individual shows to the carrier that he or she was prevented by circumstances beyond his or her control from providing timely documentation.

(2) Appropriate documentation includes, but is not limited to, copies of

birth certificates, marriage certificates, and, if applicable, other proof including that the individual lives with the enrollee and the enrollee is the individual's primary source of financial support.

(3) The effective date of a removal shall be prospective unless the record shows that the enrollee or the removed individual has committed fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the plan. If fraud or intentional misrepresentation of material fact is found, the effective date of the removal is the date of loss of eligibility.

(4) A request for reconsideration of the carrier's initial decision must be filed by the enrollee or the removed individual with the enrollee's employing office within 60 calendar days after the date of the carrier's initial decision. The employing office must notify the carrier when a request for reconsideration of the decision to remove the individual from the enrollment is made. The time limit for filing may be extended if the enrollee or the removed shows that he or she was not notified of the time limit and was not otherwise aware of it, or that he or she was prevented by circumstances beyond his or her control from making the request within the time limit. The request for reconsideration must be made in writing and must include the enrollee's name, address, Social Security Number or other personal identification number, individual's name, the name of the enrollee's carrier, reason(s) for the request, and, if applicable, the enrollee's retirement claim number.

(5) The employing office must issue a written notice of its final decision to the enrollee, and notify the carrier of the decision, within 30 days of receipt of the request for reconsideration. The notice must fully set forth the findings and conclusions on which the decision was based.

(6) If an enrollee or the removed individual provides acceptable proof of eligibility of an individual subsequent to removal, coverage under the enrollment shall be reinstated retroactively so that there is no gap in coverage, as appropriate.

(f) *Employing office and OPM removal from enrollment: Ineligible individuals.* (1) An enrollee's employing office or OPM may request verification of eligibility from the enrollee at any time of an individual who is covered as a family member of the enrollee in accordance with § 890.302. To verify eligibility, the employing office or OPM shall send the enrollee a request for appropriate documentation of the individual's relationship to the enrollee. The request shall contain a written notice that the individual will no longer be covered 60 calendar days after the date of the notice unless the enrollee provides appropriate documentation as requested. If the employing office or OPM, as applicable, does not receive the requested documentation within the specified time frame or if based on the documentation provided the individual is found not to be eligible, the employing office or OPM, as applicable, shall direct the carrier to remove the individual from the enrollment and the employing office or OPM, as applicable, shall provide written notice of the removal to the enrollee, with a copy to the carrier, including an explanation of the process for seeking reconsideration. The time limit to provide appropriate documentation may be extended if the enrollee or the removed individual shows to the employing office or OPM, as appropriate, that he or she was prevented by circumstances beyond his or her control from providing timely documentation.

(2) Appropriate documentation includes, but is not limited to, copies of birth certificates, marriage certificates, and, if applicable, other proof including that the individual lives with the enrollee and that the enrollee is the individual's primary source of financial support.

(3) The effective date of the removal shall be prospective unless the record shows that the enrollee or the removed individual has committed fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the plan. If fraud or intentional misrepresentation of material fact is found, the effective date of the removal is the date of loss of eligibility.

(4) The enrollee or the removed individual may request reconsideration of an employing office or OPM's decision to remove the individual from the enrollment within 60 days of an employing office or OPM's initial decision. The enrollee or the removed individual may request reconsideration of an employing office decision to the employing office or an OPM decision to OPM. The employing office or OPM, as applicable, must notify the carrier when a request for reconsideration of the decision to remove the individual from the enrollment is made. The time limit for filing may be extended if the enrollee or the removed individual shows that he or she was not notified of the time limit and was not otherwise aware of it, or that he or she was prevented by circumstances beyond his or her control from making the request within the time limit. The request for reconsideration must be made in writing and must include the enrollee's name, address, Social Security Number or other personal identification number, the individual's name, the name of the enrollee's carrier, reason(s) for the request, and, if applicable, the enrollee's retirement claim number.

(5) The employing office or OPM, as applicable, must issue a written notice of its final decision to the enrollee, and notify the carrier of the decision within 30 days of receipt of the request for reconsideration. The notice must fully set forth the findings and conclusions on which the decision was based.

(6) If an enrollee or the removed individual provides acceptable proof of eligibility of an individual subsequent to removal, coverage under the enrollment shall be reinstated retroactively so that there is no gap in coverage, as appropriate.

(g) *Temporary extension of coverage, conversion and/or temporary continuation of coverage.* If an individual is removed from an enrollment pursuant to paragraph (e) or (f) of this section, the individual may be eligible for a 31-day temporary extension of coverage, conversion and/or temporary continuation of coverage in accordance with §890.401 and subparts H and K of this part. Any opportunity to enroll under §890.401 and subparts H and K shall not extend beyond the date that opportunity would have ended if the individual had been removed on the date of loss of eligibility.

(1) *Example.* An enrollee and his spouse divorce on May 4, 2017. The enrollee does not remove the former spouse from the enrollee's self and family enrollment, so the former spouse is receiving coverage but is not eligible. In this example, the former spouse is not eligible to receive an annuity listed in §890.805(2). If the employing office later discovers the divorce, and removes the spouse from the enrollment on June 20, 2018, the former spouse is not eligible for a 31-day extension of coverage, conversion and/or temporary continuation of coverage because the regulatory window for election of 60 days outlined in §890.805(1) has passed. The sixty-day window began on the final date of the divorce, May 4, 2017 and ended on July 3, 2017.

(2) [Reserved]

(h) *Removal from enrollment: Eligible family members.* (1) An eligible family member may be removed from a self plus one or a self and family enrollment if a request is submitted to the enrollee's employing office for approval at any time during the plan year in the following circumstances:

(i) In the case of a spouse, if the enrollee and his or her spouse provide a notarized request for removal.

(ii) In the case of a child who has reached the age of majority in the child's state of residence (the enrollee's state of residence if the child's is not known), if the enrollee provides proof that the child is no longer his or her dependent as described under §890.302(b). The enrollee shall also provide the last known contact information for the child.

(iii) In the case of a child who has reached the age of majority in the child's state of residence, if the child provides a notarized request for removal to the employing office.

(2) For removals under paragraph (h)(1) of this section the effective date is the first day of the third pay period following the date the request is approved by the employing office for employees who pay bi-weekly and the second pay period following the date that

the request is approved by the employing office for enrollees who pay premiums monthly.

(3) The family member's removal under this paragraph (h) is considered a cancellation under § 890.304(d) and removed family members are not eligible for temporary extension of coverage and conversion under § 890.401 or temporary continuation of coverage under § 809.1103.

(4) If an eligible family member is removed under this paragraph (h), he or she may only regain coverage under the applicable self plus one or self and family enrollment if requested by the enrollee during the annual open season or within 60 days of the family member losing other health insurance coverage. The enrollee must also provide written consent to reinstatement of coverage from the family member and demonstrate eligibility of the spouse or child as a family member to the employing office.

(5) If an employing office approves a request for removal, the employing office must notify the enrollee and the carrier of the removal immediately. For removals under paragraph (h)(1)(ii) of this section, the employing office must also immediately notify the child of the removal using the last known contact provided by the enrollee.

[63 FR 59459, Nov. 4, 1998, as amended at 83 FR 3061, Jan. 23, 2018]

## Subpart D—Temporary Extension of Coverage and Conversion

### § 890.401 Temporary extension of coverage and conversion.

(a) *Thirty-one day extension and conversion.* (1) An enrollee whose enrollment is terminated other than by cancellation of the enrollment or discontinuance of the plan, in whole or part, and a covered family member whose coverage is terminated other than by cancellation of the enrollment or discontinuance of the plan, in whole or in part, is entitled to a 31-day extension of coverage for self only, self plus one, or self and family, as the case may be, without contributions by the enrollee or the Government, during which period he or she is entitled to exercise the right of conversion provided for by this part. The 31-day extension of coverage and the right of conversion for any person ends on the effective date of a new enrollment under this part covering the person.

(2) Termination of an enrollment under this subpart for failure to pay premiums is considered a cancellation of the enrollment for the purposes of this section.

(b) *Continuation of benefits.* (1) Any person who has been granted a 31-day extension of coverage in accordance with paragraph (a) of this section and who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the plan during the continuance of the confinement but not beyond the 60th day after the end of the temporary extension.

(2) Except when a plan is discontinued in whole or in part or the Associate Director for Retirement and Insurance orders an enrollment change, a person whose enrollment has been changed from one plan to another, or from one option of a plan to the other option of that plan, and who is confined to a hospital or other institution for care or treatment on the last day of enrollment under the prior plan or option, is entitled to continuation of the benefits of the prior plan or option during the continuance of the confinement. Continuation of benefits shall not extend beyond the 91st day after the last day of enrollment in the prior plan or option. The plan or option to which enrollment has been changed shall not pay benefits with respect to that person while he or she is entitled to any inpatient benefits under the prior plan or option. The gaining plan or option shall begin coverage according to the limits of its FEHB Program contract on the day after the day all inpatient benefits have been exhausted under the prior plan or option or the 92nd day after the last day of enrollment in the prior plan or option, whichever is earlier. For the purposes of this paragraph, ''exhausted'' means paid or provided to the maximum benefit available under the contract.

(3) *Exception.* The limit on the number of confinement days allowed to be covered under the continuation of benefits specified by paragraph (b)(2) of

this subpart does not apply to confinements in a hospital or other institution when the charges and benefit payments for the services provided are covered by the limit specified in subpart I of this part. In these cases, the benefits continue until the end of the confinement.

(c)(1) The employing agency must notify the enrollee of the termination of the enrollment and of the right to convert to an individual policy within 60 days after the date the enrollment terminates.

(2) The individual whose enrollment terminates must request conversion information from the losing carrier within 31 days of the date of the agency notice of the termination of the enrollment and of the right to convert.

(3) When an agency fails to provide the notification required in paragraph (c)(1) of this section within 60 days of the date the enrollment terminates, or the individual fails for other reasons beyond his or her control to request conversion as required in paragraph (c)(2) of this section, he or she may request conversion to an individual policy by writing directly to the carrier. Such a request must be filed within 6 months after the individual became eligible to convert his or her group coverage and must be accompanied by verification of termination of the enrollment; e.g., an SF 50, showing the individual's separation from the service. In addition, the individual must show that he or she was not notified of the termination of the enrollment and of the right to convert, and was not otherwise aware of it, or that he or she was unable, for cause beyond his or her control, to convert. The carrier will determine if the individual is eligible to convert; and when the determination is affirmative, the individual may convert within 31 days of the determination. If the determination by the carrier is negative, the individual may request a review of the carrier's determination from OPM.

(4) When an individual converts his or her coverage anytime after the group coverage has ended, the individual plan coverage is retroactive to the day following the day the temporary extension of group coverage ended. The individual must pay the premiums due for the retroactive period.

(5) An individual who fails to exercise his or her rights to convert to an individual policy within 31 days after receiving notice of the right to convert from the carrier is deemed to have declined the right to convert unless the carrier, or, upon review, OPM determines the failure was for cause beyond his or her control.

[33 FR 12510, Sept. 4, 1968, as amended at 52 FR 10217, Mar. 31, 1987; 54 FR 52339, Dec. 21, 1989; 55 FR 22891, June 5, 1990; 57 FR 10609, Mar. 27, 1992; 57 FR 21191, May 19, 1992; 80 FR 55736, Sept. 17, 2015]

## Subpart E—Contributions and Withholdings

AUTHORITY: 5 U.S.C. 8913; Sec. 890.303 also issued under Sec. 50 U.S.C. 403p, 22 U.S.C. 4069c and 4069c–1; Subpart L also issued under Sec. 599C of Public Law 101–513, 104 Stat. 2064, as amended; Sec. 890.102 also issued under Secs. 11202(f), 11232(e), 11246(b) and (c) of Public Law 105–33, 111 Stat. 251; Sec. 721 of Public Law 105–261, 112 Stat. 2061 unless otherwise noted; Sec. 890.111 also issued under Sec. 1622(b) of Public Law 104–106, 110 Stat. 515.

### § 890.501 Government contributions.

(a) The Government contribution toward subscription charges under all health benefits plans, for each enrolled employee who is paid biweekly, is the amount provided in section 8906 of title 5, United States Code, plus 4 percent of that amount.

(b) In accordance with the provisions of 5 U.S.C. 8906(a) which take effect with the contract year that begins in January 1999, OPM will determine the amounts representing the weighted average of subscription charges in effect for each contract year, for self only, self plus one, and self and family enrollments, as follows:

(1) The determination of the weighted average of subscription charges will only include those health benefits plans which are continuing FEHB Program participation from one contract year to the next.

(i) If OPM and the carrier for a plan that will continue participation have closed negotiations on rates for the upcoming contract year by September 1 of the current contract year, i.e., the

determination year, OPM will use the plan's negotiated subscription charges for the upcoming contract year in the determination of the weighted average of subscription charges.

(ii) If OPM and the carrier for a plan that applied to continue participation have not closed rate negotiations for the upcoming contract year by September 1 of the determination year, OPM will make a deemed adjustment to such plan's subscription charges for the current contract year for purposes of counting eligible enrollees of the plan in the determination of weighted average charges for the upcoming contract year. The deemed adjustment will equal any increase or decrease OPM finds in its determination of the weighted average of subscription charges for the upcoming contract year for all plans with which OPM has closed rates on September 1 of the determination year.

(iii) There will be no subsequent adjustment in the weighted average charges applicable to the upcoming contract year to reflect rate negotiations closed after September 1 of the determination year.

(2) Except as otherwise specified in paragraphs (b)(2) (i) and (b)(2)(ii) of this section, the weight OPM gives to each subscription charge for purposes of determining the weighted average of subscription charges for the upcoming contract year will be proportionate to the number of individuals who, as of March 31 of the determination year, are enrolled in the plan or benefits option to which such charge applies and are eligible for a Government health benefits contribution in the upcoming contract year.

(i) When a subscription charge for an upcoming contract year applies to a plan that is the result of a merger of two or more plans which contract separately with OPM during the determination year, or applies to a plan which will cease to offer two benefits options, OPM will combine the self only enrollments, the self plus one enrollments, and the self and family enrollments from the merging plans, or from a plan's benefits options, for purposes of weighting subscription charges in effect for the successor plan for the upcoming contract year.

(ii) When a comprehensive medical plan (CMP) varies subscription charges for different portions of the plan's service area and the plan's contract for the upcoming contract year will reconfigure geographic areas associated with subscription charges, so that there will not be a direct correlation between enrollment in the determination year and rating areas for the upcoming contract year, OPM will estimate what portion of the plan's enrollees on March 31 of the determination year will be subject to each of the plan's subscription rates for the upcoming contract year.

(3) After OPM weights each subscription charge as provided in paragraph (b)(2) of this section, OPM will compute the total of subscription charges associated with self only enrollments, self plus one enrollments, and self and family enrollments, respectively. OPM will divide each subscription charge total by the total number of enrollments such amount represents to obtain the program-wide weighted average subscription charges for self only and for self plus one and self and family enrollments, respectively.

(c) The Government contribution for annuitants and for employees who are not paid biweekly is a percentage of that fixed by paragraphs (a) and (b) of this section proportionate to the length of the pay period, rounding fractions of a cent to the nearest cent.

(d) The Government contribution for employees whose annual pay is paid during a period shorter than 52 workweeks is determined on an annual basis and prorated over the number of installments of pay regularly paid during the year.

(e) Except as provided in paragraphs (f) and (g) of this section, the employing office must make a contribution for an employee for each pay period during which the enrollment continues.

(f) Temporary employees enrolled under 5 U.S.C. 8906a must pay the full subscription charge including the Government contribution. Employees with provisional appointments under § 316.403 of this chapter are not considered to be enrolled under 5 U.S.C. 8906a for the purposes of this paragraph.

(g) The Government contribution for an employee who enters the uniformed

services and whose enrollment continues under § 890.303(i) ceases after 365 days in nonpay status.

(h) The Government contribution for an employee who enrolls in a health benefit plan offered through an appropriate SHOP as determined by the Director pursuant to section 1312(d)(3)(D) of the Patient Protection and Affordable Care Act, Public Law 111–148, as amended by the Health Care and Education Reconciliation Act, Public Law 111–152 (the Affordable Care Act or the Act) shall be calculated in the same manner as for other employees.

(2) Government contributions and employee withholdings for employees who enroll in a health benefit plan offered through an appropriate SHOP as determined by the Director, pursuant to section 1312(d)(3)(D) of the Patient Protection and Affordable Care Act, Public Law 111–148, as amended by the Health Care and Education Reconciliation Act, Public Law 111–152 (the Affordable Care Act or the Act) shall be accounted for pursuant to section 8909 of title 5 and such monies shall only be available for payment of premiums, and costs in accordance with section 8909(a)(2) of title 5.

[33 FR 12510, Sept. 4, 1968, as amended at 47 FR 30963, July 16, 1982; 54 FR 7756, Feb. 23, 1989; 56 FR 10143, Mar. 11, 1991; 60 FR 45658, Sept. 1, 1995; 63 FR 45934, Aug. 28, 1998; 64 FR 31488, June 11, 1999; 78 FR 60656, Oct. 2, 2013; 80 FR 55736, Sept. 17, 2015]

EDITORIAL NOTE: At 79 FR 46638, Aug. 8, 2014, § 890.501 was amended by adding paragraph (h); however, the amendatory instruction could not be followed because paragraph (h) already appeared in the section.

### § 890.502 Withholdings, contributions, LWOP, premiums, and direct premium payment.

(a) *Employee and annuitant withholdings and contributions.* (1) Employees and annuitants are responsible for paying the enrollee share of the cost of enrollment for every pay period during which they are enrolled. An employee or annuitant incurs a debt to the United States in the amount of the proper employee or annuitant withholding required for each pay period during which they are enrolled if the appropriate health benefits withholdings or direct premium payments are not made.

(2) An individual is not required to pay withholdings for the period between the end of the pay period in which he or she separates from service and the commencing date of an immediate annuity, if later.

(3) Temporary employees who are eligible to enroll under 5 U.S.C. 8906a must pay the full subscription charges including both the employee share and the Government contribution. Employees with provisional appointments under § 316.403 of this chapter are not considered eligible for coverage under 5 U.S.C. 8906a for the purpose of this paragraph.

(4) The employing office must calculate the withholding for employees whose annual pay is paid during a period shorter than 52 workweeks on an annual basis and prorate the withholding over the number of installments of pay regularly paid during the year.

(5) The employing office must make the withholding required from enrolled survivor annuitants in the following order. First, withhold from the annuity of a surviving spouse, if there is one. If that annuity is less than the amount required, withhold to the extent necessary from the annuity of the youngest child, and if necessary, from the annuity of the next older child, in succession, until the withholding is met.

(6) Surviving spouses who have a basic employee death benefit under 5 U.S.C. 8442(b)(1)(A) and annuitants whose health benefits premiums are more than the amount of their annuities may pay their portion of the health benefits premium directly to the retirement system acting as their employing office, as described in paragraph (d) of this section.

(b) *Procedures when an employee enters a leave without pay (LWOP) status or pay is insufficient to cover premium.* The employing office must tell the employee about available health benefits choices as soon as it becomes aware that an employee's premium payments cannot be made because he or she will be or is already in a leave without pay (LWOP) status or any other type of nonpay status. (This does not apply when nonpay is as a result of a lapse of appropriations.) The employing office must also tell the employee about

available choices when an employee's pay is not enough to cover the premiums.

(1) The employing office must give the employee written notice of the choices and consequences as described in paragraphs (b)(2)(i) and (ii) of this section and will send a letter by first class mail if it cannot give it to the employee directly. If it mails the notice, it is deemed to be received within 5 days.

(2) The employee must elect in writing to either continue health benefits coverage or terminate it. (Exception: An employee who is subject to a court or administrative order as discussed in § 890.301(g)(3) cannot elect to terminate his or her enrollment as long as the court/administrative order is still in effect and the employee has at least one child identified in the order who is still eligible under the FEHB Program, unless the employee provides documentation that he or she has other coverage for the child(ren).) The employee may continue coverage by choosing one of the following ways to pay and returning the signed form to the employing office within 31 days after he or she receives the notice (45 days for an employee residing overseas). When an employee mails the signed form, its postmark will be used as the date the form is returned to the employing office. If an employee elects to continue coverage, he or she must elect in writing one of the following:

(i) Pay the premium directly to the agency and keep the payments current. The employee must also agree that if he or she does not pay the premiums currently, the employing office will recover the amount of accrued unpaid premiums as a debt under paragraph (b)(2)(ii) of this section.

(ii) If the employee does not wish to pay the premium directly to the agency and keep payments current, he or she may agree that upon returning to employment or upon pay becoming sufficient to cover the premiums, the employing office will deduct, in addition to the current pay period's premiums, an amount equal to the premiums for a pay period during which the employee was in a leave without pay (LWOP) status or pay was not enough to cover premiums. The employing office will continue using this method to deduct the accrued unpaid premiums from salary until the debt is recovered in full. The employee must also agree that if he or she does not return to work or the employing office cannot recover the debt in full from salary, the employing office may recover the debt from whatever other sources it normally has available for recovery of a debt to the Federal Government.

(3) If the employee does not return the signed form within the time period described in paragraph (b)(2) of this section, the employing office will terminate the enrollment and notify the employee in writing of the termination.

(4)(i) If the employee is prevented by circumstances beyond his or her control from returning a signed form to the employing office within the time period described in paragraph (b)(2) of this section, he or she may write to the employing office and request reinstatement of the enrollment. The employee must describe the circumstances that prevented him or her from returning the form. The request for reinstatement must be made within 30 calendar days from the date the employing office gives the employee notice of the termination. The employing office will determine if the employee is eligible for reinstatement of coverage. When the determination is affirmative, the employing office will reinstate the coverage of the employee retroactive to the date of termination. If the determination is negative, the employee may request a review of the decision from the employing agency (see § 890.104).

(ii) If the employee is subject to a court or administrative order as discussed in § 890.301(g)(3), the coverage cannot terminate. If the employee does not return the signed form, the coverage will continue and the employee will incur a debt to the Federal Government as discussed in paragraphs (b)(2)(i) and (b)(2)(ii) of this section.

(5) Terminations of enrollment under paragraphs (b)(2) and (3) of this section are retroactive to the end of the last pay period in which the premium was withheld from pay. The employee and covered family members, if any, are entitled to the temporary extension of

coverage for conversion and may convert to an individual contract for health benefits. An employee whose coverage is terminated may enroll upon his or her return to duty in pay status in a position in which the employee is eligible for coverage under this part.

(c) *Procedures when agency underwithholds premiums.* (1) An agency that withholds less than the amount due for health benefits contributions from an individual's pay, annuity, or compensation must submit an amount equal to the uncollected employee contributions and any applicable agency contributions to OPM for deposit in the Employees Health Benefits Fund.

(2) The agency must make the deposit to OPM as soon as possible, but no later than 60 calendar days after it determines the amount of an under-deduction that has occurred, regardless of whether or when the agency recovers the under-deduction. A subsequent agency decision on whether to waive collection of the overpayment of pay caused by failure to properly withhold employee health benefits contributions will be made under 5 U.S.C. 5584 as implemented by 4 CFR chapter I, subchapter G, unless the agency involved is excluded from 5 U.S.C. 5584, in which case any applicable authority to waive the collection may be used.

(d) *Direct premium payments for annuitants.* (1) If an annuity, excluding an annuity under subchapter III of chapter 84 (Thrift Savings Plan), is too low to cover the health benefits premium, or if a surviving spouse receives a basic employee death benefit, the retirement system must provide written information to the annuitant or surviving spouse. The information must describe the health benefits plans available, and include the opportunity to either:

(i) Enroll in a health benefits plan in which the enrollee's share of the premium is less than the annuity amount; or

(ii) Pay the premium directly to the retirement system.

(2) The retirement system must accept direct payment for health benefits premiums in these circumstances. The annuitant or surviving spouse must continue direct payment of the premium even if the annuity increases to the extent that it covers the premium.

(3) The annuitant or surviving spouse must pay the retirement system his or her share of the premium for the enrollment for every pay period during which the enrollment continues, except for the 31-day temporary extension of coverage. The individual must make the payment after each pay period in which he or she is covered using a schedule set up by the retirement system. If the retirement system does not receive payment by the due date, it must notify the individual in writing that continued coverage depends upon payment being made within 15 days (45 days for annuitants or surviving spouses residing overseas) after the notice is received. If no subsequent payments are made, the retirement system terminates the enrollment 60 days after the date of the notice (90 days for annuitants or surviving spouses residing overseas). An annuitant or surviving spouse whose enrollment terminated due to nonpayment of premium may not reenroll or reinstate coverage unless there are circumstances beyond his or her control as provided in paragraph (d)(4) of this section.

(4) If the annuitant or surviving spouse is prevented by circumstances beyond his or her control from paying the premium within 15 days after receiving the notice, he or she may ask the retirement system to reinstate the enrollment by writing the retirement system. The individual must describe the circumstances and send the request within 30 calendar days from the termination date. The retirement system will determine if the annuitant or surviving spouse is eligible for reinstatement of coverage. When the determination is affirmative, the retirement system will reinstate the coverage retroactive to the date of termination. If the determination is negative, then the individual may request a review of the decision from the retirement system, as described in § 890.104.

(5) Termination of enrollment for failure to pay premiums within the time frame described in paragraph (d)(3) of this section is retroactive to the end of the last pay period for which payment was timely received.

(6) The retirement system will submit all direct premium payments along with its regular health benefits premiums to OPM according to procedures established by OPM.

(e) *Procedures for direct payment of premiums during LWOP after 365 days.* (1) An employee who is granted leave without pay (LWOP) under subpart L of part 630 of this chapter (Family and Medical Leave) after 365 days of continued coverage under § 890.303(e) must pay the employee contributions directly to the employing office and keep payments current.

(2) The employee must make payments after the pay period in which the employee is covered according to a schedule set up by the employing office. If the employing office does not receive the payment by the date due, it must notify the employee in writing that continued coverage depends upon payment being made within 15 days (45 days for employees residing overseas) after the notice is received. If no subsequent payments are made, the employing office terminates the enrollment 60 days after the date of the notice (90 days for enrollees residing overseas).

(3) If the enrollee was prevented by circumstances beyond his or her control from making payment within the timeframe in paragraph (e)(2) of this section, he or she may ask the employing office to reinstate the enrollment by writing to the employing office. The employee must file the request within 30 calendar days from the date of termination and must include supporting documentation.

(4) The employing office determines whether the employee is eligible for reinstatement of coverage. When the determination is affirmative, the employing office will reinstate the coverage of the employee retroactive to the date of termination. If the determination is negative, the employee may request the employing agency to review the decision as provided under § 890.104.

(5) An employee whose coverage is terminated under paragraph (e)(2) of this section may enroll if he or she returns to duty in a pay status in a position in which the employee is eligible for coverage under this part.

(f) *Uniformed services.* (1) Except as provided in paragraph (f)(2) of this section, an employee whose coverage continues under § 890.303(i) is responsible for payment of the employee share of the cost of enrollment for every pay period for which the enrollment continues for the first 365 days of continued coverage as set forth under paragraph (b) of this section. For coverage that continues after 365 days in nonpay status, the employee must pay, on a current basis, the full subscription charge, including both the employee and Government shares, plus an additional 2 percent of the full subscription charge.

(2) As provided by 5 U.S.C. 8906(e)(3), an employing agency may pay both the Government and employee contributions and any additional administrative expenses for the cost of coverage for the employee and the employee's family for a period of 24 months for employees called or ordered to active duty in support of a contingency operation on or after September 14, 2001. The payment of Government and employee contributions and any additional administrative expenses authorized by this section only applies to employees while they are serving in support of a contingency operation, and eligibility for these payments terminates when the employee ceases to be on orders for a contingency operation. Payment of these contributions and expenses is solely at the discretion of the employing agency.

[33 FR 12510, Sept. 4, 1968]

EDITORIAL NOTE: For FEDERAL REGISTER citations affecting § 890.502, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at *www.govinfo.gov*.

### § 890.503 Reserves.

(a) The enrollment charge consists of the rate approved by OPM for payment to the plan for each enrollee, plus 4 percent, of which one part is for an administrative reserve and 3 parts are for a contingency reserve for the plan.

(b) The administrative reserve is credited with the one one-hundred-and-fourth of the enrollment charge set aside for the administrative reserve. The administrative reserve is available for payment of administrative expenses of OPM incurred under this part, and

for such other purposes as may be authorized by law.

(c)(1) *Contingency reserve.* The contingency reserve for each plan is credited with—

(i) The three one-hundred-and-fourths of the enrollment charge set aside for the contingency reserve from the enrollment charges for employees and annuitants enrolled for that plan;

(ii) Amounts transferred in accordance with law from other contingency reserves and the administrative reserve;

(iii) Income from investment of the reserve;

(iv) Its proportionate share of the income from investment of the administrative reserve; and

(v) Any return of reserves of the plan.

(2) *Contingency reserve minimum balance.* The preferred minimum balance for the contingency reserve for community-rated plans is 1 month's subscription charges at the average recurring monthly rate paid from the Employees Health Benefits Fund for the plan during the most recent contract period. The preferred minimum balance for the contingency reserve for experience-rated plans is 1½ times an amount equal to the sum of an average month's paid claims plus an average month's administrative expenses and retentions, as determined under paragraph (c)(3) of this section. Amounts in excess of the preferred minimum balance for a contingency reserve account may be used with respect to the plan from which the reserve derives: To defray increases in future rates; to increase plan benefits, or to reduce contributions of eligible subscribers and the Government under the program through devices such as temporary suspension of, or reduction in, required contributions or a refund of contributions to eligible subscribers and the Government.

(3) *OPM/carrier reserve transfers.* The target level for total reserves of an experience-rated plan is 3½ times an amount equal to the sum of an average month's paid claims plus an average month's administrative expenses and retentions. Reserves include funds set aside for incurred-but-unpaid benefit claims and the ''special'' reserve representing the cumulative difference between income to the plan (subscription income plus interest on investments) and plan expenses (benefit costs plus administrative expenses and retentions). Included as carrier reserves is the balance in the letter of credit (LOC) account maintained by OPM for the plan. For the purposes of this section, an average month's paid claims is one-sixth of the total claims paid during the last 6 months of the most recent contract period, and an average month's administrative expenses and retentions is one-twelfth of the administrative expenses and retentions for the most recent contract period.

(i) When, as of the end of a contract period, the total of all the reserves for an experience-rated plan is less than the target level described in the first four sentences of paragraph (c)(3) of this section, the carrier is entitled to payment from the contingency reserve. Such contingency reserve payment shall equal the lesser of: An amount equal to the difference between the target level for the plan's reserves and the total of the reserves for the plan, or an amount equal to the excess, if any, of the contingency reserve over the preferred minimum balance. OMP must authorize this payment promptly after accepting the accounting statement for the contract period. The contingency reserve payment so authorized will be made available to the carrier's LOC account.

(ii) When, as of the end of a contract period, the total of all reserves of an experience-rated plan amounts to more than the plan's target level, the excess over the plan's target level must be credited to the contingency reserve maintained by OPM for the plan. OPM will withdraw the excess amount from the plan's LOC account, based on reporting in the annual accounting statement for the year, no sooner than May 1, of the following year. If the accounting statement is not filed by the time limit specified in the plan's contract with OPM, OPM will estimate the amount of the excess reserves and may withdraw that amount from the plan's LOC account, or begin the process of offsetting that amount from subscription payments, no sooner than May 1. The amount withdrawn from the plan's

LOC account, or offset from subscription payments, will be credited to that plan's contingency reserve.

(4) OPM may, by agreement with the carrier, approve community rating for a comprehensive plan. If the contingency reserve of the carrier of a community-rated plan exceeds the preferred minimum balance, as described in paragraph (c)(2) of this section, the carrier may request OPM to pay to the plan a portion of the reserve not greater than the excess of the contingency reserve over the preferred minimum balance. The carrier shall state the reason for the request. OPM will decide whether to allow the request in whole or in part and will advise the plan of its decision.

(5) *Special contingency reserve transfers.* In addition to those amounts, if any, paid under paragraphs (c)(2) through (c)(4) of this section, OPM may authorize such other payments from the contingency reserve as in the judgment of OPM may be in the best interest of employees and annuitants enrolled in the program. A carrier for a plan may apply to OPM at any time for a payment from the contingency reserve when the carrier has good cause, such as unexpected claims experience and variations from expected community rates. In the administration of this part, OPM will accord a high priority to deciding whether to allow requests under this paragraph in whole or in part and will promptly advise the carrier of its decision. Amounts paid from the contingency reserve under paragraphs (c)(2) through (5) of this section shall be reported as subscription income in the year in which paid. By agreement with the carrier and where good cause exists, OPM may accept payment from carrier reserves for credit to the contingency reserve in an amount and under conditions other than those specified in paragraph (c) of this section. For carriers funded by LOC, the returned amount will be withdrawn from the plan's LOC account.

(6) *Subsidization penalty reserve.* This reserve account shall be credited with all subsidization penalties levied against community rated plans outlined in 48 CFR 1615.402(c)(3)(ii)(B). The funds in this account shall be annually distributed to the contingency reserves of all community rated plans subject to the FEHB-specific medical loss ratio threshold on a pro-rata basis. The funds will not be used for one specific carrier or plan.

[33 FR 12510, Sept. 4, 1968, as amended at 37 FR 20668, Oct. 3, 1972; 43 FR 52460, Nov. 13, 1978; 51 FR 7430, Mar. 4, 1985; 52 FR 3212, Feb. 3, 1987; 54 FR 52339, Dec. 21, 1989; 55 FR 22891, June 5, 1990; 57 FR 14324, Apr. 20, 1992; 76 FR 38284, June 29, 2011]

### § 890.504 Disposition of contingency reserves upon reorganization or merger of plans.

Upon reorganization or merger of a plan, OPM must credit to the surviving plan the reserves of the reorganized or merged plan. If more than one plan survives, the reserves must be divided among the surviving plans in proportion to the number of enrollees continuing to subscribe to the surviving plans.

[54 FR 52339, Dec. 21, 1989; 55 FR 22891, June 5, 1990]

### § 890.505 Recurring premium payments to carriers.

The procedures for payment of premiums, contingency reserve, and interest distribution to FEHB Program carriers shall be those contained in 48 CFR subpart 1632.170.

[57 FR 14324, Apr. 20, 1992]

## Subpart F—Transfers From Retired Federal Employees Health Benefits Program

### § 890.601 Coverage.

An annuitant (a retired employee or survivor under part 891 of this chapter) who is enrolled, or is eligible to enroll, under the Retired Federal Employees Health Benefits Program (part 891 of this chapter) is eligible to enroll under the Federal Employees Health Benefits Program under this part.

[39 FR 20055, June 6, 1974]

### § 890.602 Opportunity to change enrollment.

An annuitant eligible to enroll under § 890.601 may elect to enroll on and after August 8, 1978.

[43 FR 35018, Aug. 8, 1978, as amended at 62 FR 38440, July 18, 1997]

### § 890.603 Effective date.

The effective date of an enrollment under § 890.602 is the first day of the first pay period after the election is received by the retirement system, but not earlier than January 1, 1979.

[43 FR 35018, Aug. 8, 1978; 43 FR 38569, Aug. 29, 1978]

### § 890.604 [Reserved]

### § 890.605 Persons confined on effective date.

Benefits may not be limited for persons who, on the effective date of an enrollment under § 890.602, are confined in a hospital or institution.

[43 FR 35018, Aug. 8, 1978]

## Subpart G [Reserved]

## Subpart H—Benefits for Former Spouses

SOURCE: 51 FR 15748, Apr. 28, 1986, unless otherwise noted.

### § 890.801 Introduction.

This subpart sets forth policies and procedures for obtaining health benefits coverage that are unique to former spouses of Federal employees and retirees.

### § 890.802 Definition.

In this subpart, a *Qualifying court order* means a court order acceptable for processing as defined in § 838.103 of this chapter or qualifying court order as defined in § 838.1003 of this chapter.

[57 FR 33599, July 29, 1992]

### § 890.803 Who may enroll.

(a) Except as specified in paragraph (b) of this section, a former spouse is eligible to enroll in a health benefits plan under this part provided that—

(1) The former spouse whose marriage to an employee, employee annuitant, or a former Central Intelligence Agency (CIA) or Foreign Service employee is dissolved has not remarried before age 55; and

(2) The former spouse was enrolled in a health benefits plan under this part as a family member at any time during the 18 months preceding the date of the dissolution of marriage; and

(3)(i) The former spouse currently receives, or has future title to receive (A) a portion of annuity payable to the employee upon retirement based on a qualifying court order for purposes of 5 U.S.C. 8345(j) or 5 U.S.C. 8467; (B) survivor annuity benefits based on a qualifying court order for purposes of 5 U.S.C. 8341(h) or 5 U.S.C. 8445; or (C) a survivor annuity elected by the employee under 5 U.S.C. 8339(j)(3) or 5 U.S.C. 8417(b), including a former spouse who is designated as an insurable interest pursuant to §§ 831.613(a) and (b) and 842.605(a) and (b) of this chapter (or benefits similar to those under this paragraph under another retirement system for Government employees); *or*

(ii) The former spouse was married to an employee who retired before May 7, 1985, and (A) the employee annuitant elects to provide a survivor annuity to the former spouse under procedures prescribed in § 831.682 of this title; or (B) the former spouse satisfies all of the conditions for a survivor annuity in § 831.683 of this title; *or*

(iii) The former spouse was married to an employee who died before May 7, 1985, and the employee was eligible for an immediate annuity on or before the date of death, *and* the former spouse satisfies all of the conditions for a survivor annuity in § 831.683 of this title, or

(iv) The former spouse was married to an employee or former employee of the Central Intelligence Agency (CIA) for at least 10 years during the employee's CIA service, at least 5 years of which both the employee and the former spouse spent outside the United States, and the marriage was dissolved before May 7, 1985; *or*,

(v) The former spouse was married to an employee or former employee of the Foreign Service for at least 10 years

during the employee's government service, and the marriage was dissolved before May 7, 1985.

(b) Except as contained in paragraphs (a)(3) (iv) and (v) of this section, a former spouse of an employee who separates from Federal service before becoming eligible for immediate annuity is eligible to enroll only if the former spouse's marriage to the employee was dissolved before the employee left Federal service.

(c) If a former spouse cannot apply for benefits on his or her own behalf because of a mental or physical disability, application may be filed by a court-appointed guardian.

[51 FR 15748, Apr. 28, 1986, as amended at 52 FR 39497, Oct. 22, 1987, and 53 FR 32368, Aug. 25, 1988; 53 FR 45070, Nov. 8, 1988; 57 FR 21192, May 19, 1992; 58 FR 52882, Oct. 13, 1993; 62 FR 38440, July 18, 1997]

### § 890.804 Coverage.

(a) *Type of enrollment.* A former spouse who meets the requirements of § 890.803 may elect coverage for self only, self plus one, or self and family. A self and family enrollment covers only the former spouse and all eligible children of both the former spouse and the employee, former employee, or employee annuitant, provided such children are not otherwise covered by a health plan under this part. A self plus one enrollment covers only the former spouse and one eligible child of both the former spouse and the employee, former employee, or employee annuitant, provided the child is not otherwise covered by a health plan under this part. A child must be under age 26 or incapable of self-support because of a mental or physical disability existing before age 26. No person may be covered by two enrollments.

(b) A child is considered to be the child of the former spouse or the employee, former employee, or employee annuitant if he or she is—

(1) A natural child; or

(2) An adopted child.

(c) *Child incapable of self-support.* When a former spouse enrolls for a family enrollment which includes a child who has become 26 years of age and is incapable of self-support, the employing office shall determine such child's eligibility in accordance with § 890.302(c), (d), and (e).

[78 FR 64877, Oct. 30, 2013, as amended at 80 FR 55737, Sept. 17, 2015]

### § 890.805 Application time limitations.

(a) Except for former spouses meeting the requirements in § 890.803(a)(3) (iv) and (v) of this part, former spouses must apply for health benefits coverage—

(1) Within 60 days after dissolution of the marriage to the Federal employee; or

(2) Within 60 days after the date of OPM's notice of eligibility to enroll based on entitlement to one of the following:

(i) A former spouse annuity elected under 5 U.S.C. 8339(j)(3), 5 U.S.C. 8417(b), or 5 CFR 831.682;

(ii) A former spouse annuity under § 831.683;

(iii) A former spouse insurable interest annuity under 5 U.S.C. 8339(k)(1) or 8420(a);

(iv) A former spouse annuity under 5 U.S.C. 8341(h) or 8445(f);

(v) An apportionment under 5 U.S.C. 8345(j) or 8467; or

(3) Within 60 days after the date of the notice of eligibility to enroll based on entitlement to a former spouse annuity under another retirement system for Government employees.

(b) Former spouses who meet the requirements in § 890.803(a)(3)(iv) of this part must apply for health benefits coverage by April 1, 1987. Where circumstances warrant, the former spouse may request that the filing date be waived. The authority of the Director of Central Intelligence to direct OPM to waive the filing date has been delegated to CIA's Office of Personnel. Requests for waiver should be addressed to the Office of Personnel, Retirement Division, Central Intelligence Agency, Washington, DC 20505. OPM will waive the April 1, 1987, filing date upon notification to do so from the Director of Central Intelligence.

(c) Former spouses who meet the requirements in § 890.803(a)(3)(v) of this part must apply for health benefits coverage by October 7, 1988. Where circumstances warrant, the former spouse may request the Secretary of State to waive the filing date. The authority of

the Secretary of State to waive the filing date has been delegated to the Department of State's Retirement Division. Requests for waiver should be addressed to the Department of State, Retirement Division, Washington, DC 20520. OPM will accept the waiver upon notification to do so from the Department of State.

[51 FR 15748, Apr. 28, 1986, as amended at 53 FR 45071, Nov. 8, 1988; 57 FR 21192, May 19, 1992; 58 FR 52882, Oct. 13, 1993; 62 FR 38440, July 18, 1997]

### § 890.806 When can former spouses change enrollment or reenroll and what are the effective dates?

(a) *Initial opportunity to enroll.* A former spouse who has met the eligibility requirements of § 890.803 and the application time limitation requirements of § 890.805 may enroll at any time after the employing office establishes that these requirements have been met.

(b) *Effective date—generally.* (1) Except as otherwise provided, an enrollment takes effect on the first day of the first pay period that begins after the date the employing office receives an appropriate request and satisfactory proof of eligibility as required by paragraph (a) of this section. If a former spouse requests immediate coverage, and the employing office receives an appropriate request and satisfactory proof of eligibility within 60 days after the date of divorce, the enrollment may be made effective on the same day that temporary continuation of coverage under subpart K of this part would otherwise take effect.

(2) A change of enrollment takes effect on the first day of the first pay period that begins after the date the employing office receives the appropriate request.

(c) *Belated enrollment.* When an employing office determines that a former spouse was unable, for cause beyond his or her control, to enroll or change the enrollment within the time limits prescribed by this section, the former spouse may do so within 60 days after the employing office advises the former spouse of its determination.

(d) *Enrollment by proxy.* Subject to the discretion of the employing office, a former spouse's representative, having written authorization to do so, may enroll or change the enrollment for the former spouse.

(e) *Decreasing enrollment type.* (1) A former spouse may decrease enrollment type at any time.

(2) A decrease in enrollment type takes effect on the first day of the first pay period that begins after the date the employing office receives an appropriate request to change the enrollment, except that at the request of the former spouse and upon a showing satisfactory to the employing office that there was no family member eligible for coverage under the self plus one or self and family enrollment, or only one family member eligible for coverage under the self and family enrollment, as appropriate, the employing office may make the change effective on the first day of the pay period following the one in which there was, in the case of a self plus one enrollment, no family member or, in the case of a self and family enrollment, only one or no family member.

(f) *Open season.* (1) During an open season as provided by § 890.301(f)—

(i) An enrolled former spouse may decrease enrollment type, increase enrollment type provided the family member(s) to be covered under the enrollment is eligible for coverage under § 890.804, change from one plan or option to another, or make any combination of these changes.

(ii) A former spouse who suspended the enrollment under this part for the purpose of enrolling in a Medicare sponsored plan under sections 1833, 1876, or 1851 of the Social Security Act, or to enroll in the Medicaid program or a similar State-sponsored program of medical assistance for the needy, or to use Peace Corps or CHAMPVA or TRICARE (including the Uniformed Services Family Health Plan) or TRICARE-for-Life coverage instead of FEHB coverage, may reenroll.

(2) An open season reenrollment or change of enrollment takes effect on the first day of the first pay period that begins in January of the next following year.

(3) When a belated open season reenrollment or change of enrollment is accepted by the employing office under paragraph (c) of this section, it takes

effect as required by paragraph (f)(2) of this section.

(g) *Change in family status.* (1) An enrolled former spouse may increase enrollment type, change from one plan or option to another, or make any combination of these changes within the period beginning 31 days before and ending 60 days after the birth or acquisition of a child who meets the eligibility requirements of § 890.804.

(2) A change in enrollment under paragraph (g)(1) of this section takes effect on the first day of the pay period in which the child is born or becomes an eligible family member.

(h) *Reenrollment of former spouses who suspended enrollment to enroll in a Medicare sponsored plan, or the Medicaid or similar State-sponsored program, or to use Peace Corps or CHAMPVA or TRICARE (including the Uniformed Services Family Health Plan) or TRICARE-for-Life coverage instead of FEHB coverage.* (1) A former spouse who had been enrolled for coverage under this part and suspended enrollment for the purpose of enrolling in a Medicare sponsored plan under sections 1833, 1876, or 1851 of the Social Security Act, or to enroll in Medicaid or similar State-sponsored program of medical assistance for the needy, or to use Peace Corps or CHAMPVA or TRICARE (including the Uniformed Services Family Health Plan) or TRICARE-for-Life coverage instead of FEHB (as provided in § 890.807(e)), or who meets the eligibility requirements of § 890.803 and the application time limitation requirements of § 890.805, but postponed enrollment in the FEHB Program for the purpose of enrolling in one of these non-FEHB programs, and who subsequently involuntarily loses coverage under one of these programs, may immediately reenroll in any available FEHB plan under this part at any time beginning 31 days before and ending 60 days after the loss of coverage. A reenrollment under this paragraph (h) of this section takes effect on the date following the effective date of the loss of coverage as shown on the documentation from the non-FEHB coverage. If the request to reenroll is not received by the employing office or retirement system within the time period specified, the former spouse must wait until the next available Open Season to reenroll.

(2) A former spouse who suspended enrollment in the FEHB Program to enroll in a Medicare sponsored plan, or the Medicaid program or a similar State-sponsored program of medical assistance for the needy, or to use Peace Corps or CHAMPVA or TRICARE (including the Uniformed Services Family Health Plan) or the TRICARE-for-Life program, but now wants to reenroll in the FEHB Program for any reason other than an involuntary loss of coverage, may do so during the next available Open Season (as provided by paragraph (f) of this section).

(i) [Reserved]

(j) *Loss of coverage under this part or under another group insurance plan.* An enrolled former spouse may decrease or increase enrollment type, change from one plan or option to another or make any combination of these changes when the former spouse or a child who meets the eligibility requirements under § 890.804 loses coverage under another enrollment under this part or under another group health benefits plan. Except as otherwise provided, the former spouse must change the enrollment within the period beginning 31 days before the date of loss of coverage and ending 60 days after the date of loss of coverage, provided he or she continues to meet the eligibility requirements under § 890.803. Losses of coverage include but are not limited to—

(1) Loss of coverage under another FEHB enrollment due to the termination, cancellation, or a change to self plus one or self only, of the covering enrollment;

(2) Loss of coverage under another federally-sponsored health benefits program;

(3) Loss of coverage due to the termination of membership in an employee organization sponsoring or underwriting an FEHB plan;

(4) Loss of coverage due to the discontinuance of an FEHB plan in whole or in part. For a former spouse who loses coverage under this paragraph (j)(4)—

(i) If the discontinuance is at the end of a contract year, the former spouse must change the enrollment during the open season, unless OPM establishes a

different time. If the discontinuance is at a time other than the end of the contract year, OPM must establish a time and effective date for the former spouse to change the enrollment;

(ii) If the whole plan is discontinued, a former spouse who does not change the enrollment within the time set will be enrolled in the lowest-cost nationwide plan option, as defined in § 890.301(n);

(iii) If one or more options of a plan are discontinued, a former spouse who does not change the enrollment will be enrolled in the remaining option of the plan, or in the case of a plan with two or more options remaining, the lowest-cost remaining option that is not a High Deductible Health Plan (HDHP);

(iv) If the discontinuance of the plan, whether permanent or temporary, is due to a disaster, the former spouse must change the enrollment within 60 days of the disaster, as announced by OPM. If a former spouse does not change the enrollment within the time frame announced by OPM, the former spouse will be enrolled in the lowest-cost nationwide plan option, as defined in § 890.301(n) of this section. The effective date of enrollment changes under this provision will be set by OPM when it makes the announcement allowing such changes;

(v) A former spouse who is unable, for causes beyond his or her control, to make an enrollment change within the 60 days following a disaster and is, as a result, enrolled in the lowest-cost nationwide plan as defined in § 890.301(n), may request a belated enrollment into the plan of his or her choice subject to the requirements of paragraph (c) of this section.

(5) Loss of coverage under the Medicaid program or similar State-sponsored program of Medical assistance for the needy.

(6) Loss of coverage under a non-Federal health plan.

(k) *Move from comprehensive medical plan's area.* A former spouse in a comprehensive medical plan who moves or becomes employed outside the geographic area from which the plan accepts enrollments, or, if already outside this area, moves or becomes employed further from this area, may change the enrollment upon notifying the employing office of the move or change of place of employment. Similarly, a former spouse whose covered family member moves outside the geographic area from which the plan accepts enrollments, or if already outside this area, moves further from this area, may change the enrollment upon notifying the employing office of the family member's move. The change of enrollment takes effect on the first day of the pay period that begins after the employing office receives an appropriate request.

(l) *On becoming eligible for Medicare.* A former spouse may change the enrollment from one plan or option to another at any time beginning on the 30th day before becoming eligible for coverage under title XVIII of the Social Security Act (Medicare). A change of enrollment based on becoming eligible for Medicare may be made only once.

(m) *Annuity insufficient to pay withholdings.* (1) If the annuity of a former spouse is insufficient to pay the full subscription charge for the plan in which he or she is enrolled, the retirement system must provide the former spouse with information regarding the available plans and written notification of the opportunity to either—

(i) Pay the premium directly to the retirement system in accordance with § 890.808(d); or

(ii) Enroll in any plan with a full premium that is less than the amount of annuity. If the former spouse elects to change to a lower cost enrollment, the change takes effect immediately upon loss of coverage under the prior enrollment.

(2) If the former spouse is enrolled in the high option of a plan that has two options, and does not elect a plan with a full premium that is less than the annuity or does not elect to pay premiums directly, he or she is deemed to have enrolled in the standard option of the same plan unless the annuity is insufficient to pay the full subscription charge for the standard option.

(3) A former spouse who is enrolled in a plan with only one option, who fails to make the election required by this

paragraph (m)(3) will be subject to the provisions of § 890.807(c).

[62 FR 38440, July 18, 1997; 62 FR 49557, Sept. 22, 1997, as amended at 66 FR 49087, Sept. 26, 2001; 67 FR 41307, June 18, 2002; 70 FR 71749, Nov. 30, 2005; 72 FR 1912, Jan. 17, 2007; 80 FR 55737, Sept. 17, 2015; 80 FR 65883, Oct. 28, 2015]

### § 890.807 When do enrollments terminate, cancel or suspend?

(a)(1) Except for former spouses meeting the requirements in § 890.803(a)(3) (iv) and (v) of this part, a former spouse's enrollment terminates, subject to the temporary extension of coverage for conversion, at midnight of the last day of the pay period in which the earliest of the following events occurs:

(i) Court order ceases to provide entitlement to survivor annuity or portion of retirement annuity under a retirement system for Government employees.

(ii) Former spouse remarries before age 55.

(iii) Former spouse dies.

(iv) Employee or annuitant on whose service the benefits are based dies and no survivor annuity is payable.

(v) Separated employee on whose service the benefits are based dies before the requirements for deferred annuity have been met.

(vi) Employee on whose service benefits are based leaves Federal service before establishing title to an immediate annuity or a deferred annuity.

(vii) Refund of retirement money is paid to the separated employee on whose service the health benefits are based.

(2) OPM may authorize a longer time frame for the temporary extension of coverage for conversion than the 31 days provided in § 890.401(a) if in OPM's judgment the former spouse could not have known that (1) the employee on whose service benefits are based left Federal service before establishing title to an immediate or deferred annuity; or (2) the separated employee on whose service the benefits are based died before the requirements for deferred annuity had been met. In such cases, the right of conversion may be exercised up to 31 days after the employing office's notice of termination. The former spouse must pay the full premium (employee's and Government's share) during the extended period, exclusive of the 31–day period following the notice.

(3) Termination of enrollment for failure to pay premiums within the time frame established in accordance with § 890.808(d)(1) is retroactive to the end of the last pay period for which payment has been timely received.

(4) A former spouse whose enrollment is terminated under this paragraph may not reenroll.

(b) The enrollment of a former spouse who meets the requirements in § 890.803(a)(3) (iv) or (v) of this part terminates, subject to the temporary extension of coverage for conversion, at midnight of the last day of the pay period in which the earliest of the following events occurs:

(1) Former spouse remarries before age 55.

(2) Former spouse dies.

(c) *Failure to make an election under § 890.806(m).* (1) If the annuity is insufficient to pay the full subscription charge due for the plan in which the former spouse is enrolled, the former spouse may elect one of the two opportunities offered under § 890.806(m) (electing a plan with a full subscription charge that is less than the annuity; or paying premiums directly to the retirement system in accordance with § 890.808(d)). Except as provided in paragraph (c)(3) of this section the enrollment of a former spouse who fails to make an election within the specified time frame will be terminated.

(2) If the individual was prevented by circumstances beyond his or her control from making an election within the time limit after receipt of the final notice, he or she may request reinstatement of coverage by writing to the retirement system. The retirement system will determine if the individual is eligible for reinstatement of coverage; and, when the determination is affirmative, the individual's coverage may be reinstated retroactively to the date of termination or prospectively. If the determination is negative, the individual may request reconsideration of the decision from OPM.

(3) If the former spouse does not make an election under paragraph (c)(1) of this section and is enrolled in

the high option of a plan that has two options, the former spouse is deemed to have elected enrollment in the standard option of the same plan unless the annuity is insufficient to pay the full withholdings for the standard option.

(d) *Coverage of members of the family.* The coverage of a member of the family of a former spouse terminates, subject to the temporary extension of coverage for conversion, at midnight of the earlier of the following dates:

(1) The day on which the individual ceases to be an eligible family member.

(2) The day the former spouse ceases to be enrolled, unless the family member is entitled as a survivor annuitant to continued enrollment or is entitled to continued coverage under the enrollment of another.

(e) *Cancellation.* (1) A former spouse may cancel his or her enrollment at any time by filing an appropriate request with the employing office. The cancellation takes effect on the last day of the pay period in which the appropriate request cancelling the enrollment is received by the employing office.

(2) A former spouse may suspend enrollment in FEHB for the purpose of enrolling in a Medicare sponsored plan under sections 1833, 1876, or 1851 of the Social Security Act, or to enroll in the Medicaid program or a similar State-sponsored program of medical assistance for the needy, or to use Peace Corps or CHAMPVA or TRICARE (including the Uniformed Services Family Health Plan) or TRICARE-for-Life coverage instead of FEHB coverage. To suspend FEHB coverage, documentation of eligibility for coverage under the non-FEHB Program must be submitted to the employing office or retirement system. If the documentation is received within the period beginning 31 days before and ending 31 days after the effective date of the enrollment in the Medicare sponsored plan, or the Medicaid or similar program, or within 31 days before or after the day designated by the former spouse as the day he or she wants to suspend FEHB coverage to use Peace Corps or CHAMPVA or TRICARE (including the Uniformed Services Family Health Plan) or TRICARE-for-Life coverage instead of FEHB coverage, then the suspension will be effective at the end of the day before the effective date of the enrollment or the end of the day before the day designated. Otherwise, the suspension is effective the first day of the first pay period that begins after the date the employing office or retirement system receives the documentation.

(3) The former spouse and family members, if any, are not entitled to the temporary extension of coverage for conversion or to convert to an individual contract for health benefits.

(4) A former spouse who cancels his or her enrollment for any reason may not later reenroll in the FEHB Program.

[51 FR 15748, Apr. 28, 1986, as amended at 52 FR 39497, Oct. 22, 1987, and 53 FR 32368, Aug. 25, 1988; 53 FR 45071, Nov. 8, 1988; 56 FR 25997, June 6, 1991; 57 FR 48162, Oct. 22, 1992; 62 FR 38441, July 18, 1997; 62 FR 53223, Oct. 14, 1997; 66 FR 49088, Sept. 26, 2001; 67 FR 41307, June 18, 2002; 70 FR 71749, Nov. 30, 2005]

### § 890.808 Employing office responsibilities.

(a) *Application for benefits.* The former spouse's application for health benefits may be in the form of a Standard Form 2809, letter, or written statement to the employing office. Former spouses applying for benefits under §890.803(a)(3)(iv) of this part must also include with their application a request for waiver of the application time limitation in accordance with §890.805(b) of this part. Former spouses applying for benefits under §890.803(a)(3)(v) of this part must also include with their application a request for waiver of the application time limitation in accordance with §890.805(c) of this part.

(b) *Administration of the enrollment process.* (1) The employing office will set up a method for accepting applications for enrollment informing the former spouse what documents to submit and where to submit them for an eligibility determination, and collecting premium payments. The method will include procedures for verifying the eligibility requirements under §890.803(a) (1) and (2) of this part. The employing office must obtain OPM,

Foreign Service Retirement and Disability System (FSRDS), or CIA Retirement and Disability System (CIARDS) documentation that the former spouse meets the additional requirement under § 890.803(a)(3) (i), (ii), (iii), (iv), or (v) of this part. A request for the retirement system's determination whether a court order is a qualifying court order for health benefits enrollment under this subpart must be accompanied by the documentation specified in § 838.221, § 838.721, or § 838.1005 of this chapter.

(2) The employing office will send the former spouse notice, in writing, of its decision. When an employing office informs a former spouse of his or her eligibility to enroll, it will identify the documents on which it based its decision and will include a premium payment schedule and statement of the requirements for continued enrollment under § 890.803. If the former spouse does not qualify for health benefits coverage, the employing office must give the former spouse a reconsideration right under § 890.104. Reconsideration requests from former spouses applying for benefits under § 890.803(a)(3)(iv) of this part must be directed to the Office of Personnel, Retirement Division, Central Intelligence Agency, Washington, DC 20505. Reconsideration requests from former spouses applying for benefits under § 890.803(a)(3)(v) of this part must be directed to the Department of State, Retirement Division, Washington, DC 20520.

(3) The agency employing office will maintain a health benefits file for the former spouse as a file separate from the personnel records of the employee or former employee. The retirement system acting as employing office for the former spouse may file the former spouse health benefits records in with the annuitant's retirement records.

(4) The former spouse will be required to certify that he or she meets the requirements listed in § 890.803 and that he or she will notify the employing office within 31 days of an event that results in failure to meet one or more of the requirements.

(c) *Qualifying court order.* Subject to a 31-day extension period for conversion, the duration of health benefits coverage will coincide with any period specified in the qualifying court order providing for an annuity. A court order not meeting the requirements under part 838 of this chapter will not be used to establish or continue entitlement to a former spouse's health benefits coverage.

(d) *Premium payments.* (1) The former spouse must remit to the employing office the full subscription charge for the enrollment for every pay period during which the enrollment continues, exclusive of the 31-day temporary extension of coverage for conversion provided in §§ 890.401 and 890.807(a)(2). Payment must be made after the pay period in which the former spouse is covered in accordance with a schedule established by the employing office (see definition of *pay period* under § 890.101(a)). If the employing office does not receive payment by the due date the employing office must notify the former spouse in writing that continuation of coverage depends upon payment being made within 15 days (45 days for enrollees residing overseas) after receipt of the notice. If no subsequent payments are made, the employing office terminates the enrollment 60 days (90 days for enrollees residing overseas) after the date of the notice. Termination for nonpayment of premium is considered a voluntary cancellation under § 890.807(d). A former spouse whose enrollment is terminated because of nonpayment of premium may not reenroll or reinstate coverage except as provided in paragraph (d)(2) of this section.

(2) If the individual was prevented by circumstances beyond his or her control from making payment within 15 days after receipt of the notice, he or she may request reinstatement of coverage by writing to the employing office. Such a request must be filed within 30 calendar days from the date of termination and must be accompanied by verification that the individual was prevented by circumstances beyond his or her control from paying within the time limit. The employing office will determine if the individual is eligible for reinstatement of coverage; and, when the determination is affirmative,

the individual's coverage may be reinstated retroactively to the date of termination. If the determination is negative, the individual may request a review of the decision from the employing agency as provided under § 890.104.

(3) The employing office will submit all premium payments collected from former spouses along with its regular health benefits payments to OPM in accordance with procedures established by that Office.

(e) *Withholding from annuity.* The retirement system acting as employing office for a former spouse will establish a method for withholding the full subscription charge from the former spouse's annuity check. When the annuity is insufficient to cover the full subscription charge, the retirement system will follow the procedures specified in § 890.806(l).

[51 FR 15748, Apr. 28, 1986, as amended at 52 FR 2506, Jan. 23, 1987; 52 FR 39497, Oct. 22, 1987, and 53 FR 32368, Aug. 25, 1988; 53 FR 45071, Nov. 8, 1988; 56 FR 25997, June 6, 1991; 57 FR 21192, May 19, 1992; 57 FR 33598, July 29, 1992; 59 FR 60297, Nov. 23, 1994; 59 FR 67607, Dec. 30, 1994; 61 FR 37810, July 22, 1996; 62 FR 38442, July 18, 1997]

## Subpart I—Limit on Inpatient Hospital Charges, Physician Charges, and FEHB Benefit Payments

SOURCE: 57 FR 10610, Mar. 27, 1992, unless otherwise noted.

### § 890.901 Purpose.

This subpart identifies the individuals whose charges and FEHB benefit payments for inpatient hospital services and/or physician services may be limited and sets forth the circumstances of the limit.

[60 FR 26668, May 18, 1995]

### § 890.902 Definition.

For purposes of this subpart, *Retired enrolled individual* means an individual who:

(a)(1) Is covered by a Federal Employees Health Benefits plan (including individuals covered under 5 U.S.C. 8905a) described by 5 U.S.C. 8903(1), (2) and (3), or 5 U.S.C. 8903a and is:

(i) An annuitant as defined in 5 U.S.C. 8901(3); or

(ii) A former spouse as defined in 5 U.S.C. 8901(10) or enrolled for continued coverage under 5 U.S.C. 8905a(f); or

(2) Is a family member covered by the family enrollment of an annuitant or former spouse as defined in 5 U.S.C. 8901, or a former spouse enrolled for continued coverage under 5 U.S.C. 8905a(f); and

(b) Is not employed in a position which confers FEHB coverage; and

(c) Is age 65 or older or becomes age 65 while receiving inpatient hospital services or physician services; and

(d) Is not covered by Medicare part A and/or part B.

[57 FR 10610, Mar. 27, 1992, as amended at 60 FR 26668, May 18, 1995]

### § 890.903 Covered services.

(a) The limitation on the charges and FEHB benefit payments for inpatient hospital services apply to inpatient hospital services which are:

(1) Covered under both Medicare part A and the retired enrolled individual's FEHB plan; and

(2) Supplied to a retired enrolled individual who does not have Medicare part A; and

(3) Provided by hospital providers who have in force participation agreements with the Secretary of Health and Human Services (HHS) consistent with sections 1814(a) and 1866 of the Social Security Act, and receive Medicare part A payments in accordance with the diagnosis related group (DRG) based prospective payment system (PPS).

(b) The limitation on the charges and FEHB benefit payments for physician services apply to physician services, (as defined in section 1848(j) of the Social Security Act), which are:

(1) Covered under both Medicare part B and the retired enrolled individual's FEHB plan; and

(2) Supplied to a retired enrolled individual who does not have Medicare part B.

[60 FR 26668, May 18, 1995]

### § 890.904 Determination of FEHB benefit payment.

(a) The FEHB plan's benefit payment for inpatient hospital services under this subpart is the amount calculated by the FEHB plan, using information and instructions provided by the Department of Health and Human Services (HHS) and guidelines specified by OPM, as equivalent to the Medicare Part A payment under the DRG-based PPS (this is, the amount payable before the Medicare deductible, coinsurance and lifetime limits are applied), reduced by any FEHB plan deductible, coinsurance, copayment, or preadmission certification penalty that is the responsibility of the retired enrolled individual.

(b) The FEHB plan's benefit payment for physician services under this subpart is determined by taking the lower of the following amounts:

(1) The amount determined by the FEHB plan, which is equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule for Medicare participating physicians and the Medicare Nonparticipating Physician Fee Schedule for Medicare nonparticipating physicians (the amount payable before the Medicare deductible and coinsurance are applied); or

(2) The actual billed charges; and

(3) Reducing the lower amount by any FEHB plan deductible, coinsurance, or copayment that is the responsibility of the retired enrolled individual.

[58 FR 38663, July 20, 1993, as amended at 60 FR 26668, May 18, 1995]

### § 890.905 Limits on inpatient hospital and physician charges.

(a) Hospitals may not collect from FEHB plans and retired enrolled individuals for inpatient hospital services more than the amount determined to be equivalent to the Medicare part A payment under the DRG-based PPS.

(b) Medicare participating providers may not collect from FEHB plans and retired enrolled individuals for physician services more than the amount determined to be equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule.

(c) Medicare nonparticipating providers may not collect from FEHB plans and retired enrolled individuals for physician services more than the amount determined to be equivalent to the Medicare limiting charge amount.

[60 FR 26668, May 18, 1995; 60 FR 28019, May 26, 1995]

### § 890.906 Retired enrolled individuals coinsurance payments.

(a) A retired enrolled individual's coinsurance responsibility for inpatient hospital services is calculated in accordance with the plan's contractual benefit structure and is based on the amount determined to be equivalent to the Medicare part A payment under the DRG-based PPS.

(b) A retired enrolled individual's coinsurance responsibility for physician services is calculated in accordance with the plan's contractual benefit structure and is based on the lower of the actual charges or the amount determined to be equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule for Medicare participating physicians and the Medicare Nonparticipating Physician Fee Schedule for Medicare nonparticipating physicians.

[60 FR 26668, May 18, 1995]

### § 890.907 Effective dates.

(a) The limitation specified in this subpart applies to inpatient hospital admissions commencing on or after January 1, 1992.

(b) The limitation specified in this subpart applies to physician services supplied on or after January 1, 1995.

[60 FR 26668, May 18, 1995]

### § 890.908 Notification of HHS.

An FEHB plan, under the oversight of OPM, will notify the Secretary of HHS, or the Secretary's designee, if the plan finds that:

(a) A hospital knowingly and willfully collects, on a repeated basis, more than the amount determined to be equivalent to the Medicare part A payment under the DRG-based PPS.

(b) A Medicare participating physician or supplier knowingly and willfully collects, on a repeated basis, more

than the amount determined to be equivalent to the Medicare part B payment under the Medicare Participating Physician Fee Schedule.

(c) A Medicare nonparticipating physician or supplier knowingly and willfully charges, on a repeated basis, more than the amount determined to be equivalent to the Medicare limiting charge amount.

[60 FR 26668, May 18, 1995]

### § 890.909 End-of-year settlements.

Neither OPM, nor the FEHB plans, will perform end-of-year settlements with, or make retroactive adjustments as a result of retroactive changes in the Medicare payment calculation information to, hospital providers who have received FEHB benefit payments under this subpart.

[57 FR 10610, Mar. 27, 1992. Redesignated at 60 FR 26668, May 18, 1995]

### § 890.910 Provider information.

The hospital provider information used to calculate the amount equivalent to the Medicare part A payment will be updated on an annual basis.

[57 FR 10610, Mar. 27, 1992. Redesignated at 60 FR 26668, May 18, 1995]

## Subpart J—Administrative Sanctions Imposed Against Health Care Providers

AUTHORITY: 5 U.S.C. 8902a.

SOURCE: 68 FR 5475, Feb. 3, 2003, unless otherwise noted.

GENERAL PROVISIONS AND DEFINITIONS

### § 890.1001 Scope and purpose.

(a) *Scope.* This subpart implements 5 U.S.C. 8902a, as amended by Public Law 105–266 (October 19, 1998). It establishes a system of administrative sanctions that OPM may, or in some cases, must apply to health care providers who have committed certain violations. The sanctions include debarment, suspension, civil monetary penalties, and financial assessments.

(b) *Purpose.* OPM uses the authorities in this subpart to protect the health and safety of the persons who obtain their health insurance coverage through the FEHBP and to assure the financial and programmatic integrity of FEHBP transactions.

### § 890.1002 Use of terminology.

Unless otherwise indicated, within this subpart the words ''health care provider,'' ''provider,'' and ''he'' mean a health care provider(s) of either gender or as a business entity, in either the singular or plural. The acronym ''OPM'' and the pronoun ''it'' connote the U.S. Office of Personnel Management.

### § 890.1003 Definitions.

In this subpart:

*Carrier* means an entity responsible for operating a health benefits plan described by 5 U.S.C. 8903 or 8903a.

*Community* means a geographically-defined area in which a provider furnishes health care services or supplies and for which he may request a limited waiver of debarment in accordance with this subpart. *Defined service area* has the same meaning as community.

*Contest* means a health care provider's request for the debarring or suspending official to reconsider a proposed sanction or the length or amount of a proposed sanction.

*Control interest* means that a health care provider:

(1) Has a direct and/or indirect ownership interest of 5 percent or more in an entity;

(2) Owns a whole or part interest in a mortgage, deed of trust, note, or other obligation secured by the entity or the entity's property or assets, equating to a direct interest of 5 percent or more of the total property or assets of the entity;

(3) Serves as an officer or director of the entity, if the entity is organized as a corporation;

(4) Is a partner in the entity, if the entity is organized as a partnership;

(5) Serves as a managing employee of the entity, including but not limited to employment as a general manager, business manager, administrator, or other position exercising, either directly or through other employees, operational or managerial control over the activities of the entity or any portion of the entity;

(6) Exercises substantive control over an entity or a critical influence over the activities of the entity or some portion of thereof, whether or not employed by the entity; or

(7) Acts as an agent of the entity.

*Conviction* or *convicted* has the meaning set forth in 5 U.S.C. 8902a(a)(1)(C).

*Covered individual* means an employee, annuitant, family member, or former spouse covered by a health benefits plan described by 5 U.S.C. 8903 or 8903a or an individual eligible to be covered by such a plan under 5 U.S.C. 8905(d).

*Days* means calendar days, unless specifically indicated otherwise.

*Debarment* means a decision by OPM's debarring official to prohibit payment of FEHBP funds to a health care provider, based on 5 U.S.C. 8902a (b), (c), or (d) and this subpart.

*Debarring official* means an OPM employee authorized to issue debarments and financial sanctions under this subpart.

*FEHBP* means the Federal Employees Health Benefits Program.

*Health care services or supplies* means health care or services and supplies such as diagnosis and treatment; drugs and biologicals; supplies, appliances and equipment; and hospitals, clinics, or other institutional entities that furnish supplies and services.

*Incarceration* means imprisonment, or any type of confinement with or without supervised release, including but not limited to home detention, community confinement, house arrest, or similar arrangements.

*Limited waiver* means an approval by the debarring official of a health care provider's request to receive payments of FEHBP funds for items or services rendered in a defined geographical area, notwithstanding debarment, because the provider is the sole community provider or sole source of essential specialized services in a community.

*Mandatory debarment* means a debarment based on 5 U.S.C. 8902a(b).

*Office* or *OPM* means the United States Office of Personnel Management or the component thereof responsible for conducting the administrative sanctions program described by this subpart.

*Permissive debarment* means a debarment based on 5 U.S.C. 8902a(c) or (d).

*Provider* or *provider of health care services or supplies* means a physician, hospital, clinic, or other individual or entity that, directly or indirectly, furnishes health care services or supplies.

*Reinstatement* means a decision by OPM to terminate a health care provider's debarment and to restore his eligibility to receive payment of FEHBP funds.

*Sanction* or *administrative sanction* means any administrative action authorized by 5 U.S.C. 8902a or this subpart, including debarment, suspension, civil monetary penalties, and financial assessments.

*Should know* or *should have known* has the meaning set forth in 5 U.S.C. 8902a(a)(1)(D).

*Sole community provider* means a provider who is the only source of primary medical care within a defined service area.

*Sole source of essential specialized services in a community* means a health care provider who is the only source of specialized health care items or services in a defined service area and that items or services furnished by a non-specialist cannot be substituted without jeopardizing the health or safety of covered individuals.

*Suspending official* means an OPM employee authorized to issue suspensions under 5 U.S.C. 8902a and this subpart.

MANDATORY DEBARMENTS

### § 890.1004 Bases for mandatory debarments.

(a) *Debarment required.* OPM shall debar a provider who is described by any category of offense set forth in 5 U.S.C. 8902a(b).

(b) *Direct involvement with an OPM program unnecessary.* The conduct underlying the basis for a provider's mandatory debarment need not have involved an FEHBP covered individual or transaction, or any other OPM program.

### § 890.1005 Time limits for OPM to initiate mandatory debarments.

OPM shall send a provider a written notice of a proposed mandatory debarment within 6 years of the event that

forms the basis for the debarment. If the basis for the proposed debarment is a conviction, the notice shall be sent within 6 years of the date of the conviction. If the basis is another agency's suspension, debarment, or exclusion, the OPM notice shall be sent within 6 years of the effective date of the other agency's action.

### § 890.1006 Notice of proposed mandatory debarment.

(a) *Written notice.* OPM shall inform a provider of his proposed debarment by written notice sent not less than 30 days prior to the proposed effective date.

(b) *Contents of the notice.* The notice shall contain information indicating the:

(1) Effective date of the debarment;

(2) Minimum length of the debarment;

(3) Basis for the debarment;

(4) Provisions of law and regulation authorizing the debarment;

(5) Effect of the debarment;

(6) Provider's right to contest the debarment to the debarring official;

(7) Provider's right to request OPM to reduce the length of debarment, if it exceeds the minimum period required by law or this subpart; and

(8) Procedures the provider shall be required to follow to apply for reinstatement at the end of his period of debarment, and to seek a waiver of the debarment on the basis that he is the sole health care provider or the sole source of essential specialized services in a community.

(c) *Methods of sending notice.* OPM shall send the notice of proposed debarment and the final decision notice (if a contest is filed) to the provider's last known address by first class mail, or, at OPM's option, by express delivery service.

(d) *Delivery to attorney, agent, or representatives.* (1) If OPM proposes to debar an individual health care provider, it may send the notice of proposed debarment directly to the provider or to any other person designated by the provider to act as a representative in debarment proceedings.

(2) In the case of a health care provider that is an entity, OPM shall deem notice sent to any owner, partner, director, officer, registered agent for service of process, attorney, or managing employee as constituting notice to the entity.

(e) *Presumed timeframes for receipt of notice.* OPM computes timeframes associated with the delivery notices described in paragraph (c) of this section so that:

(1) When OPM sends notice by a method that provides a confirmation of receipt, OPM deems that the provider received the notice at the time indicated in the confirmation; and

(2) When OPM sends notice by a method that does not provide a confirmation of receipt, OPM deems that the provider received the notice 5 business days after it was sent.

(f) *Procedures if notice cannot be delivered.* (1) If OPM learns that a notice was undeliverable as addressed or routed, OPM shall make reasonable efforts to obtain a current and accurate address, and to resend the notice to that address, or it shall use alternative methods of sending the notice, in accordance with paragraph (c) of this section.

(2) If a notice cannot be delivered after reasonable followup efforts as described in paragraph (f)(1) of this section, OPM shall presume that the provider received notice 5 days after the latest date on which a notice was sent.

(g) *Use of electronic means to transmit notice.* [Reserved]

### § 890.1007 Minimum length of mandatory debarments.

(a) *Debarment based on a conviction.* The statutory minimum period of debarment for a mandatory debarment based on a conviction is 3 years.

(b) *Debarment based on another agency's action.* A debarment based on another Federal agency's debarment, suspension, or exclusion remains in effect until the originating agency terminates its sanction.

### § 890.1008 Mandatory debarment for longer than the minimum length.

(a) *Aggravating factors.* OPM may debar a provider for longer than the 3-year minimum period for mandatory debarments if aggravating factors are

associated with the basis for the debarment. The factors OPM considers to be aggravating are:

(1) Whether the FEHBP incurred a financial loss as the result of the acts underlying the conviction, or similar acts that were not adjudicated, and the level of such loss. In determining the amount of financial loss, OPM shall not consider any amounts of restitution that a provider may have paid;

(2) Whether the sentence imposed by the court included incarceration;

(3) Whether the underlying offense(s), or similar acts not adjudicated, occurred repeatedly over a period of time, and whether there is evidence that the offense(s) was planned in advance;

(4) Whether the provider has a prior record of criminal, civil, or administrative adjudication of related offenses or similar acts; or

(5) Whether the actions underlying the conviction, or similar acts that were not adjudicated, adversely affected the physical, mental, or financial well-being of one or more covered individuals or other persons.

(b) *Mitigating factors.* If the aggravating factors justify a debarment longer than the 3 year minimum period for mandatory debarments, OPM shall also consider whether mitigating factors may justify reducing the debarment period to not less than 3 years. The factors that OPM considers to be mitigating are:

(1) Whether the conviction(s) on which the debarment is based consist entirely or primarily of misdemeanor offenses;

(2) Whether court records, including associated sentencing reports, contain an official determination that the provider had a physical, mental, or emotional condition before or during the commission of the offenses underlying the conviction that reduced his level of culpability; or

(3) Whether the provider's cooperation with Federal and/or State investigative officials resulted in criminal convictions, civil recoveries, or administrative actions against other individuals, or served as the basis for identifying program weaknesses. Restitution made by the provider for funds wrongfully, improperly, or illegally received from Federal or State programs may also be considered as a mitigating circumstance.

(c) *Maximum period of debarment.* There is no limit on the maximum period of a mandatory debarment based on a conviction.

### § 890.1009 Contesting proposed mandatory debarments.

(a) *Contesting the debarment.* Within 30 days after receiving OPM's notice of proposed mandatory debarment, a provider may submit information, documents, and written arguments in opposition to the proposed debarment. OPM's notice shall contain specific information about where and how to submit this material. If a timely contest is not filed, the proposed debarment shall become effective as stated in the notice, without further action by OPM.

(b) *Requesting a reduction of the debarment period.* If OPM proposes a mandatory debarment for a period longer than the 3-year minimum required by 5 U.S.C. 8902a(g)(3), the provider may request a reduction of the debarment period to not less than 3 years, without contesting the debarment itself.

(c) *Personal appearance before the debarring official.* In addition to providing written material, the provider may appear before the debarring official personally or through a representative to present oral arguments in support of his contest. OPM's notice shall contain specific information about arranging an in-person presentation.

### § 890.1010 Debarring official's decision of contest.

(a) *Prior adjudication is dispositive.* Evidence indicating that a provider was formally adjudicated for a violation of any type set forth in 5 U.S.C. 8902a(b) fully satisfies the standard of proof for a mandatory debarment.

(b) *Debarring official's decision.* The debarring official shall issue a written decision, based on the entire administrative record, within 30 days after the record closes to receipt of information. The debarring official may extend this decision period for good cause.

(c) *No further administrative proceedings.* The debarring official's decisions regarding mandatory debarment and the period of debarment are final

and are not subject to further administrative review.

PERMISSIVE DEBARMENTS

### § 890.1011 Bases for permissive debarments.

(a) *Licensure actions.* OPM may debar a health care provider to whom the provisions of 5 U.S.C. 8902a(c)(1) apply. OPM may take this action even if the provider retains current and valid professional licensure in another State(s).

(b) *Ownership or control interests.* OPM may debar a health care provider based on ownership or control of or by a debarred provider, as set forth in 5 U.S.C. 8902a(c)(2) and (3).

(c) *False, deceptive, or wrongful claims practices.* OPM may debar a provider who commits claims-related violations as set forth in 5 U.S.C. 8902a(c)(4) and (5) and 5 U.S.C. 8902a(d)(1) and (2).

(d) *Failure to furnish required information.* OPM may debar a provider who knowingly fails to provide information requested by an FEHBP carrier or OPM, as set forth in 5 U.S.C. 8902a(d)(3).

### § 890.1012 Time limits for OPM to initiate permissive debarments.

(a) *Licensure cases.* If the basis for the proposed debarment is a licensure action, OPM shall send the provider a notice of proposed debarment within 6 years of the effective date of the State licensing authority's revocation, suspension, restriction, or nonrenewal action, or the date on which the provider surrendered his license to the State authority.

(b) *Ownership or control.* If the basis for the proposed debarment is ownership or control of an entity by a sanctioned person, or ownership or control of a sanctioned entity by a person who knew or should have known of the basis for the entity's sanction, OPM shall send a notice of proposed debarment within 6 years of the effective date of the sanction on which the proposed debarment is based.

(c) *False, deceptive, or wrongful claims practices.* If the basis for the proposed debarment involves a claim filed with a FEHBP carrier, OPM shall send the provider a notice of proposed debarment within 6 years of the date he presented the claim for payment to the covered person's FEHBP carrier.

(d) *Failure to furnish requested information.* If the basis for the proposed debarment involves a provider's failure to furnish information requested by OPM or an FEHBP carrier, OPM shall send the notice of proposed debarment within 6 years of the date on which the carrier or OPM requested the provider to furnish the information in question.

### § 890.1013 Deciding whether to propose a permissive debarment.

(a) *Review factors.* The factors OPM shall consider in deciding whether to propose a provider's debarment under a permissive debarment authority are:

(1) The nature of any claims involved in the basis for the proposed debarment and the circumstances under which they were presented to FEHBP carriers;

(2) The improper conduct involved in the basis for the proposed debarment, and the provider's degree of culpability and history of prior offenses;

(3) The extent to which the provider poses or may pose a risk to the health and safety of FEHBP-covered individuals or to the integrity of FEHBP transactions; and

(4) Other factors specifically relevant to the provider's debarment that shall be considered in the interests of fairness.

(b) *Absence of a factor.* The absence of a factor shall be considered neutral, and shall have no effect on OPM's decision.

(c) *Specialized review in certain cases.* In determining whether to propose debarment under 5 U.S.C 8902a(c)(4) for providing items or services substantially in excess of the needs of a covered individual or for providing items or services that fail to meet professionally-recognized quality standards, OPM shall obtain the input of trained reviewers, based on written medical protocols developed by physicians. If OPM cannot reach a decision on this basis, it shall consult with a physician in an appropriate specialty area.

### § 890.1014 Notice of proposed permissive debarment.

Notice of a proposed permissive debarment shall contain the information set forth in § 890.1006.

### § 890.1015 Minimum and maximum length of permissive debarments.

(a) *No mandatory minimum or upper limit on length of permissive debarment.* There is neither a mandatory minimum debarment period nor a limitation on the maximum length of a debarment under any permissive debarment authority.

(b) *Debarring official's process in setting period of permissive debarment.* The debarring official shall set the period of each debarment issued under a permissive debarment authority after considering the factors set forth in § 890.1016 and the factors set forth in the applicable section from among §§ 890.1017 through 890.1021.

### § 890.1016 Aggravating and mitigating factors used to determine the length of permissive debarments.

(a) *Aggravating factors.* The presence of aggravating circumstances may support an OPM determination to increase the length of a debarment beyond the nominal periods set forth in §§ 890.1017 through 890.1021. The factors that OPM considers as aggravating are:

(1) Whether the provider's actions underlying the basis for the debarment, or similar acts, had an adverse impact on the physical or mental health or well-being of one or more FEHBP-covered individuals or other persons.

(2) Whether the provider has a documented history of prior criminal wrongdoing; civil violations related to health care items or services; improper conduct; or administrative violations addressed by a Federal or State agency. OPM may consider matters involving violence, patient abuse, drug abuse, or controlled substances convictions or violations to be particularly serious.

(3) Whether the provider's actions underlying the basis for the debarment, or similar acts, resulted in financial loss to the FEHBP, FEHBP-covered individuals, or other persons. In determining whether, or to what extent, a financial loss occurred, OPM shall not consider any amounts of restitution that the provider may have paid.

(4) Whether the provider's false, wrongful, or improper claims to FEHBP carriers were numerous, submitted over a prolonged period of time, or part of an on-going pattern of wrongful acts.

(5) Whether the provider was specifically aware of or directly responsible for the acts constituting the basis for the debarment.

(6) Whether the provider attempted to obstruct, hinder, or impede official inquiries into the wrongful conduct underlying the debarment.

(b) *Mitigating factors.* The presence of mitigating circumstances may support an OPM determination to shorten the length of a debarment below the nominal periods set forth in §§ 890.1017 through 890.1021, respectively. The factors that OPM considers as mitigating are:

(1) Whether the provider's cooperation with Federal, State, or local authorities resulted in criminal convictions, civil recoveries, or administrative actions against other violators, or served as the basis for official determinations of program weaknesses or vulnerabilities. Restitution that the provider made for funds wrongfully, improperly, or illegally received from Federal or State programs may also be considered as a mitigating factor.

(2) Whether official records of judicial proceedings or the proceedings of State licensing authorities contain a formal determination that the provider had a physical, mental, or emotional condition that reduced his level of culpability before or during the period in which he committed the violations in question.

(c) *Absence of factors.* The absence of aggravating or mitigating factors shall have no effect to either increase or lower the nominal period of debarment.

### § 890.1017 Determining length of debarment based on revocation or suspension of a provider's professional licensure.

(a) *Indefinite term of debarment.* Subject to the exceptions set forth in paragraph (b) of this section, debarment under 5 U.S.C. 8902a(c)(1) shall be for an indefinite period coinciding with the

period during which the provider's license is revoked, suspended, restricted, surrendered, or otherwise not in effect in the State whose action formed the basis for OPM's debarment.

(b) *Aggravating circumstances.* If any of the aggravating circumstances set forth in § 890.1016 apply, OPM may debar the provider for an additional period beyond the duration of the licensure revocation or suspension.

### § 890.1018 Determining length of debarment for an entity owned or controlled by a sanctioned provider.

OPM shall determine the length of debarments of entities under 5 U.S.C. 8902a(c)(2) based on the type of violation committed by the person with an ownership or control interest. The types of violations actionable under this provision are:

(a) *Owner/controller's debarment.* The debarment of an entity based on debarment of an individual with an ownership or control interest shall be for a period concurrent with the individual's debarment. If any aggravating or mitigating circumstances set forth in § 890.1016 apply solely to the entity and were not considered in setting the period of the individual's debarment, OPM may debar the entity for a period longer or shorter than the individual's debarment.

(b) *Owner/controller's conviction.* The debarment of an entity based on the criminal conviction of a person with an ownership or control interest for an offense listed in 5 U.S.C. 8902a(b)(1)–(4) shall be for a period of not less than 3 years, subject to adjustment for any aggravating or mitigating circumstances set forth in § 890.1016 applying solely to the entity.

(c) *Owner/controller's civil monetary penalty.* The debarment of an entity based on a civil monetary penalty imposed on a person with an ownership or control interest, shall be for a period of not less than 3 years, subject to adjustment for any aggravating or mitigating circumstances set forth in § 890.1016 applying solely to the entity.

### § 890.1019 Determining length of debarment based on ownership or control of a sanctioned entity.

OPM shall determine the length of debarments of individual providers under 5 U.S.C. 8902a(c)(3) based on the type of violation committed by the sanctioned entity owned or controlled by the person with an ownership or control interest. The types of violations actionable under this provision are:

(a) *Entity's debarment.* If a provider's debarment is based on his ownership or control of a debarred entity, the debarment shall be concurrent with the entity's debarment. If any of the aggravating or mitigating circumstances identified in § 890.1016 applies directly to the provider that owns or controls the debarred entity and was not considered in setting the period of the entity's debarment, OPM may debar the provider for a period longer or shorter, respectively, than the entity's debarment.

(b) *Entity's conviction.* If a provider's debarment is based on the criminal conviction of an entity he owns or controls for an offense listed in 5 U.S.C. 8902a(b)(1)–(4), OPM shall debar the provider for a period of no less than 3 years, subject to adjustment for any aggravating or mitigating circumstances identified in § 890.1016 that apply to the provider as an individual.

(c) *Entity's civil monetary penalty.* If a provider's debarment is based on a civil monetary penalty imposed on an entity he owns or controls, OPM shall debar him for 3 years, subject to adjustment on the basis of the aggravating and mitigating circumstances listed in § 890.1016 that apply to the provider as an individual.

### § 890.1020 Determining length of debarment based on false, wrongful, or deceptive claims.

Debarments under 5 U.S.C. 8902a(c)(4) and (5) and 5 U.S.C. 8902a(d)(1) and (2) shall be for a period of 3 years, subject to adjustment based on the aggravating and mitigating factors listed in § 890.1016.

### § 890.1021 Determining length of debarment based on failure to furnish information needed to resolve claims.

Debarments under 5 U.S.C. 8902a(d)(3) shall be for a period of 3 years, subject to adjustment based on the aggravating and mitigating factors listed in § 890.1016.

### § 890.1022 Contesting proposed permissive debarments.

(a) *Right to contest a proposed debarment.* A provider proposed for debarment under a permissive debarment authority may challenge the debarment by filing a written contest with the debarring official during the 30-day notice period indicated in the notice of proposed debarment. In the absence of a timely contest, the debarment shall become effective as stated in the notice, without further action by OPM.

(b) *Challenging the length of a proposed debarment.* A provider may contest the length of the proposed debarment, while not challenging the debarment itself, or may contest both the length of a debarment and the debarment itself in the same contest.

### § 890.1023 Information considered in deciding a contest.

(a) *Documents and oral and written arguments.* A provider may submit documents and written arguments in opposition to the proposed debarment and/or the length of the proposed debarment, and may appear personally or through a representative before the debarring official to provide other relevant information.

(b) *Specific factual basis for contesting the proposed debarment.* A provider's oral and written arguments shall identify the specific facts that contradict the basis for the proposed debarment as stated in the notice of proposed debarment. A general or unsupported denial of the basis for debarment does not raise a genuine dispute over facts material to the debarment, and the debarring official shall not give such a denial any probative weight.

(c) *Mandatory disclosures.* Regardless of the basis for the contest, providers are required to disclose certain types of background information, in addition to any other information submitted during the contest. Failure to provide such information completely and accurately may be a basis for OPM to initiate further legal or administrative action against the provider. The specific items of information that shall be furnished to OPM are:

(1) Any existing, proposed, or prior exclusion, debarment, penalty, or other sanction imposed on the provider by a Federal, State, or local government agency, including any administrative agreement that purports to affect only a single agency;

(2) Any criminal or civil legal proceeding not referenced in the notice of proposed debarment that arose from facts relevant to the basis for debarment stated in the notice; and

(3) Any entity in which the provider has a control interest, as that term is defined in § 890.1003.

### § 890.1024 Standard and burden of proof for deciding contests.

OPM shall demonstrate, by a preponderance of the evidence in the administrative record as a whole, that a provider has committed a sanctionable violation.

### § 890.1025 Cases where additional fact-finding is not required.

In each contest, the debarring official shall determine whether a further fact-finding proceeding is required in addition to presentation of arguments, documents, and information. An additional fact-finding proceeding is not required when:

(a) *Prior adjudication.* The proposed debarment is based on facts determined in a prior due process adjudication. Examples of prior due process proceedings include, but are not limited to, the adjudication procedures associated with:

(1) Licensure revocation, suspension, restriction, or nonrenewal by a State licensing authority;

(2) Debarment, exclusion, suspension, civil monetary penalties, or similar legal or administrative adjudications by Federal, State, or local agencies;

(3) A criminal conviction or civil judgment; or

(4) An action by a provider that constitutes a waiver of his right to a due process adjudication, such as surrender

of professional license during the pendency of a disciplinary hearing, entering a guilty plea or confession of judgment in a judicial proceeding, or signing a settlement agreement stipulating facts that constitute a sanctionable violation.

(b) *Material facts not in dispute.* The provider's contest does not identify a bona fide dispute concerning facts material to the basis for the proposed debarment.

### § 890.1026 Procedures if a fact-finding proceeding is not required.

(a) *Debarring official's procedures.* If a fact-finding proceeding is not required, the debarring official shall issue a final decision of a provider's contest within 30 days after the record closes for submitting evidence, arguments, and information as part of the contest. The debarring official may extend this timeframe for good cause.

(b) *No further administrative review available.* There are no further OPM administrative proceedings after the presiding official's final decision. A provider adversely affected by the decision may appeal under 5 U.S.C. 8902a(h)(2) to the appropriate U.S. district court.

### § 890.1027 Cases where an additional fact-finding proceeding is required.

(a) *Criteria for holding fact-finding proceeding.* The debarring official shall request another OPM official (''presiding official'') to hold an additional fact-finding proceeding if:

(1) Facts material to the proposed debarment have not been adjudicated in a prior due process proceeding; and

(2) These facts are genuinely in dispute, based on the entire administrative record available to the debarring official.

(b) *Qualification to serve as presiding official.* The presiding official is designated by the OPM Director or another OPM official authorized by the Director to make such designations. The presiding official shall be a senior official who is qualified to conduct informal adjudicative proceedings and who has had no previous contact with the proposed debarment or the contest.

(c) *Effect on contest.* The debarring official shall defer a final decision on the contest pending the results of the fact-finding proceeding.

### § 890.1028 Conducting a fact-finding proceeding.

(a) *Informal proceeding.* The presiding official may conduct the fact-finding proceedings as informally as practicable, consistent with principles of fundamental fairness. Formal rules of evidence or procedure do not apply to these proceedings.

(b) *Proceeding limited to disputed material facts.* The presiding official shall consider only the genuinely disputed facts identified by the debarring official as material to the basis for the debarment. Matters that have been previously adjudicated or that are not in bona fide dispute within the administrative record shall not be considered by presiding official.

(c) *Provider's right to present information, evidence, and arguments.* A provider may appear before the presiding official with counsel, submit oral and written arguments and documentary evidence, present witnesses on his own behalf, question any witnesses testifying in support of the debarment, and challenge the accuracy of any other evidence that the agency offers as a basis for the debarment.

(d) *Record of proceedings.* The presiding official shall make an audio recording of the proceedings and shall provide a copy to the provider at no charge. If the provider wishes to have a transcribed record, OPM shall arrange for production of one which may be purchased at cost.

(e) *Presiding official's findings.* The presiding official shall resolve all of the disputed facts identified by the debarring official, on the basis of a preponderance of the evidence contained within the entire administrative record. The presiding official shall issue a written report of all findings of fact to the debarring official within 30 days after the record of the fact-finding proceeding closes.

### § 890.1029 Deciding a contest after a fact-finding proceeding.

(a) *Findings shall be accepted.* The debarring official shall accept the presiding official's findings of fact, unless

they are arbitrary, capricious, or clearly erroneous. If the debarring official concludes that the factual findings are not acceptable, they may be remanded to the presiding official for additional proceedings in accordance with § 890.1028.

(b) *Timeframe for final decision.* The debarring official shall issue a final written decision on a contest within 30 days after receiving the presiding official's findings. The debarring official may extend this decision period for good cause.

(c) *Debarring official's final decision.* (1) The debarring official shall observe the evidentiary standards and burdens of proof stated in § 890.1024 in reaching a final decision.

(2) In any case where a final decision is made to debar a provider, the debarring official has the discretion to set the period of debarment, subject to the factors identified in §§ 890.1016 through 1021.

(3) The debarring official has the discretion to decide not to impose debarment in any case involving a permissive debarment authority.

(d) *No further administrative proceedings.* No further administrative proceedings shall be conducted after the debarring official's final decision in a contest involving an additional fact-finding hearing. A provider adversely affected by the debarring official's final decision in a contested case may appeal under 5 U.S.C. 8902a(h)(2) to the appropriate U. S. district court.

SUSPENSION

### § 890.1030 Effect of a suspension.

(a) *Temporary action pending formal proceedings.* Suspension is a temporary action pending completion of an investigation or ensuing criminal, civil, or administrative proceedings.

(b) *Immediate effect.* Suspension is effective immediately upon the suspending official's decision, without prior notice to the provider.

(c) *Effect equivalent to debarment.* The effect of a suspension is the same as the effect of a debarment. A suspended provider may not receive payment from FEHBP funds for items or services furnished to FEHBP-covered persons while suspended.

### § 890.1031 Grounds for suspension.

(a) *Basis for suspension.* OPM may suspend a provider if:

(1) OPM obtains reliable evidence indicating that one of the grounds for suspension listed in paragraph (b) of this section applies to the provider; and

(2) The suspending official determines under paragraph (c) of this section that immediate action to suspend the provider is necessary to protect the health and safety of persons covered by FEHBP.

(b) *Grounds for suspension.* Evidence constituting grounds for a suspension may include, but is not limited to:

(1) Indictment or conviction of a provider for a criminal offense that is a basis for mandatory debarment under this subpart;

(2) Indictment or conviction of a provider for a criminal offense that reflects a risk to the health, safety, or well-being of FEHBP-covered individuals;

(3) Other credible evidence indicating, in the judgment of the suspending official, that a provider has committed a violation that would warrant debarment under this subpart. This may include, but is not limited to:

(i) Civil judgments;

(ii) Notice that a Federal, State, or local government agency has debarred, suspended, or excluded a provider from participating in a program or revoked or declined to renew a professional license; or

(iii) Other official findings by Federal, State, or local bodies that determine factual or legal matters.

(c) *Determining need for immediate action.* Suspension is intended to protect the public interest, including the health and safety of covered individuals or the integrity of FEHBP funds. The suspending official has wide discretion to decide whether to suspend a provider. A specific finding of immediacy or necessity is not required to issue a suspension. The suspending official may draw reasonable inferences from the nature of the alleged misconduct and from a provider's actual or potential transactions with the FEHBP.

### § 890.1032 Length of suspension.

(a) *Initial period.* The initial term of all suspensions shall be an indefinite period not to exceed 12 months.

(b) *Formal legal proceedings not initiated.* If formal legal or administrative proceedings have not begun against a provider within 12 months after the effective date of his suspension, the suspending official may:

(1) Terminate the suspension; or

(2) If requested by the Department of Justice, the cognizant United States Attorney's Office, or other responsible Federal, State, or local prosecuting official, extend the suspension for an additional period, not to exceed 6 months.

(c) *Formal proceedings initiated.* If formal criminal, civil, or administrative proceedings are initiated against a suspended provider, the suspension may continue indefinitely, pending the outcome of those proceedings.

(d) *Terminating the suspension.* The suspending official may terminate a suspension at any time, and shall terminate it after 18 months, unless formal proceedings have begun within that period.

### § 890.1033 Notice of suspension.

(a) *Written notice.* OPM shall send written notice of suspension according to the procedures and methods described in § 890.1006(c)–(f).

(b) *Contents of notice.* The suspension notice shall contain information indicating that:

(1) The provider has been suspended, effective on the date of the notice;

(2) The initial period of the suspension;

(3) The basis for the suspension;

(4) The provisions of law and regulation authorizing the suspension;

(5) The effect of the suspension; and

(6) The provider's rights to contest the suspension.

### § 890.1034 Counting a period of suspension as part of a subsequent debarment.

The debarring official may consider the provider's contiguous period of suspension when determining the length of a debarment.

### § 890.1035 Provider contests of suspensions.

(a) *Filing a contest of the suspension.* A provider may challenge a suspension by filing a contest, in writing, with the suspending official not later than 30 days after receiving notice of suspension. The suspension shall remain in effect during the contest, unless rescinded by the suspending official.

(b) *Informal proceeding.* The suspending official shall use informal, flexible procedures to conduct the contest. Formal rules of evidence and procedure do not apply to this proceeding.

### § 890.1036 Information considered in deciding a contest.

(a) *Presenting information and arguments to the suspending official.* A provider may submit documents and written arguments in opposition to the suspension, and may appear personally, or through a representative, before the suspending official to provide any other relevant information.

(b) *Specific factual basis for contesting the suspension.* The provider shall identify specific facts that contradict the basis for the suspension as stated in the suspension notice. A general denial of the basis for suspension does not raise a genuine dispute over facts material to the suspension, and the suspending official shall not give such a denial any probative weight.

(c) *Mandatory disclosures.* Any provider contesting a suspension shall disclose the items of information set forth in § 890.1023(c). Failure to provide such information completely and accurately may be a basis for OPM to initiate further legal or administrative action against the provider.

### § 890.1037 Cases where additional fact-finding is not required.

The suspending official may decide a contest without an additional fact-finding process if:

(a) *Previously adjudicated facts.* The suspension is based on an indictment or on facts determined by a prior adjudication in which the provider was afforded due process rights. Examples of due process proceedings include, but are not limited to, the adjudication procedures associated with licensure revocation, suspension, restriction, or

nonrenewal by a State licensing authority; similar administrative adjudications by Federal, State, or local agencies; a criminal conviction or civil judgment; or an action by the provider that constitutes a waiver of his right to a due process adjudication, such as surrender of professional licensure during the pendency of a disciplinary hearing, entering a guilty plea or confession of judgment in a judicial proceeding, or signing a settlement agreement stipulating facts that constitute a sanctionable violation. Neither the existence of the prior adjudication nor any of the underlying circumstances are considered to be subject to genuine factual dispute as part of the suspension proceeding.

(b) *Advisory by law enforcement officials.* OPM is advised by the Department of Justice, the appropriate U.S. Attorney's Office, a State attorney general's office, or a State or local prosecutor's office that proceedings before a presiding official would prejudice the substantial interests of the Government in pending or contemplated legal proceedings based on the same facts as the suspension.

(c) *No bona fide dispute of material facts.* The information, arguments, and documents submitted to the suspending official do not establish that there is a *bona fide* factual dispute regarding facts material to the suspension.

### § 890.1038 Deciding a contest without additional fact-finding.

(a) *Written decision.* The suspending official shall issue a written decision on the contest within 30 days after the record closes for submitting evidence, arguments, and information. The suspending official may extend this timeframe for good cause.

(b) *No further administrative review available.* The suspending official's decision is final and is not subject to further administrative review.

### § 890.1039 Cases where additional fact-finding is required.

(a) *Criteria for holding fact-finding proceeding.* The debarring official shall request another OPM official (''presiding official'') to hold an additional fact-finding proceeding if:

(1) Facts material to the suspension have not been adjudicated in a prior due process proceeding; and

(2) These facts are genuinely in dispute, based on the entire administrative record available to the debarring official.

(b) *Qualification to serve as presiding official.* The presiding official is designated by the OPM Director or another OPM official authorized by the Director to make such designations. The presiding official shall be a senior official who is qualified to conduct informal adjudicative proceedings and who has had no previous contact with the suspension or the contest.

(c) *Effect on contest.* The suspending official shall defer a final decision on the contest pending the results of the fact-finding proceeding.

### § 890.1040 Conducting a fact-finding proceeding.

(a) *Informal proceeding.* The presiding official may conduct the fact-finding proceedings as informally as practicable, consistent with principles of fundamental fairness. Specific rules of evidence or procedure do not apply to these proceedings.

(b) *Proceeding limited to disputed material facts.* The presiding official shall consider only the genuinely disputed facts identified by the suspending official as relevant to the basis for the suspension. Matters that have been previously adjudicated or which are not in bona fide dispute within the record shall not be considered by the presiding official.

(c) *Right to present information, evidence, and arguments.* A provider may appear before the presiding official with counsel, submit oral and written arguments and documentary evidence, present witnesses, question any witnesses testifying in support of the suspension, and challenge the accuracy of any other evidence that the agency offers as a basis for the suspension.

(d) *Record of proceedings.* The presiding official shall make an audio recording of the proceedings and shall provide a copy to the provider at no charge. If the provider wishes to have a transcribed record, OPM shall arrange for production of one which may be purchased at cost.

(e) *Presiding official's findings.* The presiding official shall resolve all of the disputed facts identified by the suspending official, on the basis of a preponderance of the evidence in the entire administrative record. Within 30 days after the record of the proceeding closes, the presiding official shall issue a written report of all findings of fact to the suspending official.

### § 890.1041 Deciding a contest after a fact-finding proceeding.

(a) *Presiding official's findings shall be accepted.* The suspending official shall accept the presiding official's findings, unless they are arbitrary, capricious, or clearly erroneous.

(b) *Suspending official's decision.* Within 30 days after receiving the presiding official's report, the suspending official shall issue a final written decision that either sustains, modifies, or terminates the suspension. The suspending official may extend this period for good cause.

(c) *Effect on subsequent debarment or suspension proceedings.* A decision by the suspending official to modify or terminate a suspension shall not prevent OPM from subsequently debarring the same provider, or any other Federal agency from either suspending or debarring the provider, based on the same facts.

## EFFECT OF DEBARMENT

### § 890.1042 Effective dates of debarments.

(a) *Minimum notice period.* A debarment shall take effect not sooner than 30 days after the date of OPM's notice of proposed debarment, unless the debarring official specifically determines that the health or safety of covered individuals or the integrity of the FEHBP warrants an earlier effective date. In such a situation, the notice shall specifically inform the provider that the debarring official decided to shorten or eliminate the 30-day notice period.

(b) *Uncontested debarments.* If a provider does not file a contest within the 30-day notice period, the proposed debarment shall take effect on the date stated in the notice of proposed debarment, without further procedures, actions, or notice by OPM.

(c) *Contested debarments and requests for reducing the period of debarment.* If a provider files a contest within the 30-day notice period, the proposed debarment shall not go into effect until the debarring official issues a final written decision, unless the health or safety of covered individuals or the integrity of the FEHBP requires the debarment to be effective while the contest is pending.

### § 890.1043 Effect of debarment on a provider.

(a) *FEHBP payments prohibited.* A debarred provider is not eligible to receive payment, directly or indirectly, from FEHBP funds for items or services furnished to a covered individual on or after the effective date of the debarment. Also, a provider shall not accept an assignment of a claim for items or services furnished to a covered individual during the period of debarment. These restrictions shall remain in effect until the provider is reinstated by OPM.

(b) *Governmentwide effect.* Debarment precludes a provider from participating in all other Federal agencies' procurement and nonprocurement programs and activities, as required by section 2455 of the Federal Acquisition Streamlining Act of 1994 (Pub. L. 103–355). Other agencies may grant a waiver or exception under their own regulations, to permit a provider to participate in their programs, notwithstanding the OPM debarment.

(c) *Civil or criminal liability.* A provider may be subject to civil monetary penalties under this subpart or criminal liability under other Federal statutes for knowingly filing claims, causing claims to be filed, or accepting payment from FEHBP carriers for items or services furnished to a covered individual during a period of debarment .

## NOTIFYING OUTSIDE PARTIES ABOUT DEBARMENT AND SUSPENSION ACTIONS

### § 890.1044 Entities notified of OPM-issued debarments and suspensions.

When OPM debars or suspends a provider under this subpart, OPM shall notify:

(a) All FEHBP carriers;

(b) The General Services Administration, for publication in the comprehensive Governmentwide list of Federal agency exclusions;

(c) Other Federal agencies that administer health care or health benefits programs; and

(d) State and local agencies, authorities, boards, or other organizations with health care licensing or certification responsibilities.

### § 890.1045 Informing persons covered by FEHBP about debarment or suspension of their provider.

FEHBP carriers are required to notify covered individuals who have obtained items or services from a debarred or suspended provider within one year of the date of the debarment or suspension of:

(a) The existence of the provider's debarment or suspension;

(b) The minimum period remaining in the provider's period of debarment; and

(c) The requirement that OPM terminate the debarment or suspension before FEHBP funds can be paid for items or services the provider furnishes to covered individuals.

## Exceptions to the Effect of Debarments

### § 890.1046 Effect of debarment or suspension on payments for services furnished in emergency situations.

A debarred or suspended health care provider may receive FEHBP funds paid for items or services furnished on an emergency basis if the FEHBP carrier serving the covered individual determines that:

(a) The provider's treatment was essential to the health and safety of the covered individual; and

(b) No other source of equivalent treatment was reasonably available.

[69 FR 9920, Mar. 3, 2004]

### § 890.1047 Special rules for institutional providers.

(a) *Covered individual admitted before debarment or suspension.* If a covered person is admitted as an inpatient before the effective date of an institutional provider's debarment or suspension, that provider may continue to receive payment of FEHBP funds for inpatient institutional services until the covered person is released or transferred, unless the debarring or suspending official terminates payments under paragraph (b) of this section.

(b) *Health and safety of covered individuals.* If the debarring or suspending official determines that the health and safety of covered persons would be at risk if they remain in a debarred or suspended institution, OPM may terminate FEHBP payments at any time.

(c) *Notice of payment limitations.* If OPM limits any payment under paragraph (b) of this section, it must immediately send written notice of its action to the institutional provider.

(d) *Finality of debarring or suspending official's decision.* The debarring or suspending official's decision to limit or deny payments under paragraph (b) of this section is not subject to administrative review or reconsideration.

[69 FR 9920, Mar. 3, 2004]

### § 890.1048 Waiver of debarment for a provider that is the sole source of health care services in a community.

(a) *Application required.* A provider may apply for a limited waiver of debarment at any time after receiving OPM's notice of proposed debarment. Suspended providers are not eligible to request a waiver of suspension.

(b) *Criteria for granting waiver.* To receive a waiver, a provider shall clearly demonstrate that:

(1) The provider is the *sole community provider* or the *sole source of essential specialized services in a community;*

(2) A limited waiver of debarment would be in the best interests of covered individuals in the defined service area;

(3) There are reasonable assurances that the actions which formed the basis for the debarment shall not recur; and

(4) There is no basis under this subpart for continuing the debarment.

(c) *Waiver applies only in the defined service area.* A limited waiver applies only to items or services provided within the defined service area where a provider is the *sole community provider* or *sole source of essential specialized services.*

(d) *Governmentwide effect continues.* A limited waiver applies only to a provider's FEHBP transactions. Even if OPM waives a debarment for FEHBP purposes, the governmentwide effect under section 2455 of the Federal Acquisition Streamlining Act of 1994 (Pub. L. 103–355) continues for all other Federal agencies' procurement and nonprocurement programs and activities.

(e) *Waiver rescinded if circumstances change.* OPM shall rescind the limited waiver when any of its underlying bases no longer apply. If OPM rescinds the limited waiver, the provider's debarment shall resume full effect for all FEHBP transactions. Events warranting rescission include, but are not limited to:

(1) The provider ceases to furnish items or services in the defined service area;

(2) Another provider begins to furnish equivalent items or services in the defined service area, so that the provider who received a waiver is no longer the sole provider or sole source; or

(3) The actions that formed the basis for the provider's debarment, or similar acts, recur.

(f) *Effect on period of debarment.* The minimum period of debarment is established when the debarment is initially imposed. A subsequent decision to grant, deny, or rescind a limited waiver shall not change that period.

(g) *Application is necessary for reinstatement.* A provider who has received a limited waiver shall apply for reinstatement at the end of the debarment period, even if a limited waiver is in effect when the debarment expires.

(h) *Finality of debarring official's decision.* The debarring official's decision to grant or deny a limited waiver is final and not subject to further administrative review or reconsideration.

SPECIAL EXCEPTIONS TO PROTECT COVERED PERSONS

### § 890.1049 Claims for non-emergency items or services furnished by a debarred or suspended provider.

(a) *Covered individual unaware of debarment or suspension.* FEHBP funds may be paid for items or services furnished by a debarred or suspended provider if, at the time the items or services were furnished, the covered individual did not know, and could not reasonably be expected to have known, that the provider was debarred or suspended. This provision is intended solely to protect the interests of FEHBP-covered persons who obtain services from a debarred or suspended provider in good faith and without knowledge that the provider has been sanctioned. It does not authorize debarred or suspended providers to submit claims for payment to FEHBP carriers.

(b) *Notice sent by carrier.* When paying a claim under the authority of paragraph (a) of this section, an FEHBP carrier must send a written notice to the covered individual, stating:

(1) That the provider is debarred or suspended and is prohibited from receiving payment of FEHBP funds for items or services furnished after the effective date of the debarment or suspension;

(2) That claims may not be paid for items or services furnished by the debarred or suspended provider after the covered individual is informed of the debarment or suspension;

(3) That the current claim is being paid as a legally-authorized exception to the effect of the debarment or suspension in order to protect covered individuals who obtain items or services without knowledge of their provider's debarment or suspension;

(4) That FEHBP carriers are required to deny payment of any claim for items or services rendered by a debarred or suspended provider 15 days or longer after the date of the notice described in paragraph (b) of this section, unless the covered individual had no knowledge of the provider's debarment or suspension when the items or services were rendered;

(5) The minimum period remaining in the provider's debarment or suspension; and

(6) That FEHBP funds cannot otherwise be paid to the provider until OPM terminates the debarment or suspension.

[69 FR 9920, Mar. 3, 2004]

### § 890.1050 Exception to a provider's debarment for an individual enrollee.

(a) *Request by a covered individual.* Any individual enrolled in FEHBP may submit a request through their FEHBP carrier for continued payment of items or services furnished by a debarred provider to any person covered under the enrollment. Requests shall not be accepted for continued payments to suspended providers.

(b) *OPM action on the request.* OPM shall consider the recommendation of the FEHBP carrier before acting on the request. To be approved, the request shall demonstrate that:

(1) Interrupting an existing, ongoing course of treatment by the provider would have a detrimental effect on the covered individual's health or safety; or

(2) The covered individual does not have access to an alternative source of the same or equivalent health care items or services within a reasonably accessible service area.

(c) *Scope of the exception.* An approved exception applies only to the covered individual(s) who requested it, or on whose behalf it was requested. The governmentwide effect of the provider's debarment under section 2455 of the Federal Acquisition Streamlining Act (Pub. L. 103–355) is not altered by an exception.

(d) *Provider requests not allowed.* OPM shall not consider an exception request submitted by a provider on behalf of a covered individual.

(e) *Debarring official's decision is final.* The debarring official's decision on an exception request is not subject to further administrative review or reconsideration.

## REINSTATEMENT

### § 890.1051 Applying for reinstatement when period of debarment expires.

(a) *Application required.* Reinstatement is not automatic when the minimum period of a provider's debarment expires. The provider shall apply in writing to OPM, supplying specific information about the reinstatement criteria outlined in paragraph (c) of this section.

(b) *Reinstatement date.* A debarred provider may submit a reinstatement application not earlier than 60 days before the nominal expiration date of the debarment. However, in no case shall OPM reinstate a provider before the minimum period of debarment expires.

(c) *Reinstatement criteria.* To be approved, the provider's reinstatement application shall clearly demonstrate that:

(1) There are reasonable assurances that the actions resulting in the provider's debarment have not recurred and will not recur;

(2) There is no basis under this subpart for continuing the provider's debarment; and

(3) There is no pending criminal, civil, or administrative action that would subject the provider to debarment by OPM.

(d) *Written notice of OPM action.* OPM shall inform the provider in writing of its decision regarding the reinstatement application.

(e) *Limitation on reapplication.* If OPM denies a provider's reinstatement application, the provider is not eligible to reapply for 1 year after the date of the denial.

### § 890.1052 Reinstatements without application.

OPM shall reinstate a provider without a reinstatement application if:

(a) *Conviction reversed.* The conviction on which the provider's debarment was based is reversed or vacated by a final decision of the highest appeals court with jurisdiction over the case; and the prosecutorial authority with jurisdiction over the case has declined to retry it, or the deadline for retrial has expired without action by the prosecutor.

(b) *Sanction terminated.* A sanction imposed by another Federal agency, on which the debarment was based, is terminated by that agency.

(c) *Court order.* A Federal court orders OPM to stay, rescind, or terminate a provider's debarment.

(d) *Written notice.* When reinstating a provider without an application, OPM shall send the provider written notice of the basis and effective date of his reinstatement.

### § 890.1053 Table of procedures and effective dates for reinstatements.

The procedures and effective dates for reinstatements under this subpart are:

| Basis for debarment | Application required? | Effective date |
|---|---|---|
| Period of debarment expires | Yes | After debarment expires. |
| Conviction reversed on final appeal/no retrial possible | No | Retroactive (start of debarment). |
| Other agency sanction ends | No | Ending date of sanction. |
| Court orders reinstatement | No | Retroactive (start of debarment). |

### § 890.1054 Agencies and entities to be notified of reinstatements.

OPM shall inform the FEHBP carriers, Government agencies and other organizations that were originally notified of a provider's debarment when a provider is reinstated under § 890.1051 or § 890.1052.

### § 890.1055 Contesting a denial of reinstatement.

(a) *Obtaining reconsideration of the initial decision.* A provider may contest OPM's decision to deny a reinstatement application by submitting documents and written arguments to the debarring official within 30 days of receiving the notice described in § 890.1051(d). In addition, the provider may request to appear in person to present oral arguments to the debarring official. The provider may be accompanied by counsel when making a personal appearance.

(b) *Debarring official's final decision on reinstatement.* The debarring official shall issue a final written decision, based on the entire administrative record, within 30 days after the record closes to receipt of information. The debarring official may extend the decision period for good cause.

(c) *Finality of debarring official's decision.* The debarring official's final decision regarding a provider's reinstatement is not subject to further administrative review or reconsideration.

## CIVIL MONETARY PENALTIES AND FINANCIAL ASSESSMENTS

SOURCE: 69 FR 9921, Mar. 3, 2004, unless otherwise noted.

### § 890.1060 Purpose and scope of civil monetary penalties and assessments.

(a) *Civil monetary penalty.* A civil monetary penalty is an amount that OPM may impose on a health care provider who commits one of the violations listed in § 890.1061. Penalties are intended to protect the integrity of FEHBP by deterring repeat violations by the same provider and by reducing the likelihood of future violations by other providers.

(b) *Assessment.* An assessment is an amount that OPM may impose on a provider, calculated by reference to the claims involved in the underlying violations. Assessments are intended to recognize monetary losses, costs, and damages sustained by OPM as the result of a provider's violations.

(c) *Definitions.* In §§ 890.1060 through 890.1072:

*Penalty* means civil monetary penalty; and

*Penalties and assessments* may connote the singular or plural forms of either of those terms, and may represent either the conjunctive or disjunctive sense.

(d) *Relationship to debarment and suspension.* In addition to imposing penalties and assessments, OPM may concurrently debar or suspend a provider from participating in the FEHBP on the basis of the same violations.

(e) *Relationship to other penalties provided by law.* The penalties, assessments, debarment, and suspension imposed by OPM are in addition to any other penalties that may be prescribed by law or regulation administered by an agency of the Federal Government or any State.

### § 890.1061 Bases for penalties and assessments.

(a) *Improper claims.* OPM may impose penalties and assessments on a provider if a claim presented by that provider for payment from FEHBP funds meets the criteria set forth in 5 U.S.C. 8902a(d)(1).

(b) *False or misleading statements.* OPM may impose penalties and assessments on a provider who makes a false statement or misrepresentation as set forth in 5 U.S.C. 8902a(d)(2).

(c) *Failing to provide claims-related information.* OPM may impose penalties and assessments on a provider who knowingly fails to provide claims-related information as otherwise required by law.

### § 890.1062 Deciding whether to impose penalties and assessments.

(a) *Authority of debarring official.* The debarring official has discretionary authority to impose penalties and assessments in accordance with 5 U.S.C. 8902a and this subpart.

(b) *Factors to be considered.* In deciding whether to impose penalties and assessments against a provider that has committed one of the violations identified in § 890.1061, OPM must consider:

(1) The number and frequency of the provider's violations;

(2) The period of time over which the violations were committed;

(3) The provider's culpability for the specific conduct underlying the violations;

(4) The nature of any claims involved in the violations and the circumstances under which the claims were presented to FEHBP carriers;

(5) The provider's history of prior offenses or improper conduct, including any actions that could have constituted a basis for a suspension, debarment, penalty, or assessment by any Federal or State agency, whether or not any sanction was actually imposed;

(6) The monetary amount of any damages, losses, and costs, as described in § 890.1064(c), attributable to the provider's violations; and

(7) Such other factors as justice may require.

(c) *Additional factors when penalty or assessment is based on provisions of § 890.1061(b) or (c).* In the case of violations involving false or misleading statements or the failure to provide claims-related information, OPM must also consider:

(1) The nature and circumstances of the provider's failure to properly report information; and

(2) The materiality and significance of the false statements or misrepresentations the provider made or caused to be made, or the information that the provider knowingly did not report.

### § 890.1063 Maximum amounts of penalties and assessments.

OPM may impose penalties and assessments in amounts not to exceed those set forth in U.S.C. 8902a(d).

### § 890.1064 Determining the amounts of penalties and assessments to be imposed on a provider.

(a) *Authority of debarring official.* The debarring official has discretionary authority to set the amounts of penalties and assessments in accordance with law and this subpart.

(b) *Factors considered in determining amounts of penalties and assessments.* In determining the amounts of penalties and assessments to impose on a provider, the debarring official must consider:

(1) The Government's interests in being fully compensated for all damages, losses, and costs associated with the provider's violations, including:

(i) Amounts wrongfully paid from FEHBP funds as the result of the provider's violations and interest on those amounts, at rates determined by the Department of the Treasury;

(ii) All costs incurred by OPM in investigating a provider's sanctionable misconduct; and

(iii) All costs incurred in OPM's administrative review of the case, including every phase of the administrative sanctions processes described by this subpart;

(2) The Government's interests in deterring future misconduct by health care providers;

(3) The provider's personal financial situation, or, in the case of an entity, the entity's financial situation;

(4) All of the factors set forth in § 890.1062(b) and (c); and

(5) The presence of aggravating or less serious circumstances, as described in paragraphs (c)(1) through (c)(7) of this section.

(c) *Aggravated and less serious circumstances.* The presence of aggravating circumstances may cause OPM to impose penalties and assessments at

a higher level within the authorized range, while less serious violations may warrant sanctions of relatively lower amounts. Paragraphs (c)(1) through (c)(7) of this section provide examples of aggravated and less serious violations. These examples are illustrative only, and are not intended to represent an exhaustive list of all possible types of violations.

(1) The existence of many separate violations, or of violations committed over an extended period of time, constitutes an aggravating circumstance. OPM may consider conduct involving a small number of violations, committed either infrequently or within a brief period of time, to be less serious.

(2) Violations for which a provider had direct knowledge of the material facts (for example, submitting claims that the provider knew to contain false, inaccurate, or misleading information), or for which the provider did not cooperate with OPM's or an FEHBP carrier's investigations, constitute aggravating circumstances. OPM may consider violations where the provider did not have direct knowledge of the material facts, or in which the provider cooperated with post-violation investigative efforts, to be less serious.

(3) Violations resulting in substantial damages, losses, and costs to OPM, the FEHBP, or FEHBP-covered persons constitute aggravating circumstances. Violations producing a small or negligible overall financial impact may be considered to be less serious.

(4) A pattern of conduct reflecting numerous improper claims, high-dollar false claims, or improper claims involving several types of items or services constitutes aggravating circumstances. OPM may consider a small number of improper claims for relatively low dollar amounts to be less serious.

(5) Every violation involving any harm, or the risk of harm, to the health and safety of an FEHBP enrollee, must be considered an aggravating circumstance.

(6) Any prior violation described in § 890.1062(b)(5) constitutes an aggravating circumstance. OPM may consider repeated or multiple prior violations to represent an especially serious form of aggravating circumstances.

(7) OPM may consider other circumstances or actions to be aggravating or less serious within the context of an individual case, as the interests of justice require.

### § 890.1065 Deciding whether to suspend or debar a provider in a case that also involves penalties and assessments.

In a case where both penalties and assessments and debarment are proposed concurrently, OPM must decide the proposed debarment under the same criteria and procedures as if it had been proposed separately from penalties and assessments.

### § 890.1066 Notice of proposed penalties and assessments.

(a) *Written notice.* OPM must inform a provider of proposed penalties and assessments by written notice, sent via certified mail with return receipt requested, to the provider's last known street or post office address. OPM may, at its discretion, use an express service that furnishes a verification of delivery instead of postal mail.

(b) *Statutory limitations period.* OPM must send the notice to the provider within 6 years of the date on which the claim underlying the proposed penalties and assessments was presented to an FEHBP carrier. If the proposed penalties and assessments do not involve a claim presented for payment, OPM must send the notice within 6 years of the date of the actions on which the proposed penalties and assessments are based.

(c) *Contents of the notice.* OPM's notice must contain, at a minimum:

(1) The statement that OPM proposes to impose penalties and/or assessments against the provider;

(2) Identification of the actions, conduct, and claims that comprise the basis for the proposed penalties and assessments;

(3) The amount of the proposed penalties and assessments, and an explanation of how OPM determined those amounts;

(4) The statutory and regulatory bases for the proposed penalties and assessments; and

(5) Instructions for responding to the notice, including specific explanations regarding:

(i) The provider's right to contest the imposition and/or amounts of penalties and assessments before they are formally imposed; and

(ii) OPM's right, if the provider does not contest the proposed penalties and assessments within 30 days of the date he receives the notice, to implement them immediately without further administrative appeal or recourse.

(d) *Proposing debarment in the same notice.* OPM may propose a provider's debarment in the same notice that also proposes penalties and assessments. In this case, the notice must also provide the elements of information required to appear in a notice of proposed debarment under § 890.1006(b).

(e) *Procedures if the notice cannot be delivered.* OPM must apply the provisions of § 890.1006(f) if the notice of proposed penalties and assessments cannot be delivered as originally addressed.

(f) *Sending notice by electronic means.* [Reserved]

### § 890.1067 Provider contests of proposed penalties and assessments.

(a) *Contesting proposed sanctions.* A provider may formally contest the proposed penalties and assessments by sending a written notice to the debarring official within 30 days after receiving the notice described in § 890.1066. The debarring official must apply the administrative procedures set forth in §§ 890.1069 and 890.1070 to decide the contest.

(b) *Contesting debarments and financial sanctions concurrently.* If OPM proposes debarment and penalties and assessments in the same notice, the provider may contest both the debarment and the financial sanctions in the same proceeding. If the provider pursues a combined contest, the requirements set forth in §§ 890.1022 through 890.1024, as well as this section, apply.

(c) *Settling or compromising proposed sanctions.* The debarring official may settle or compromise proposed sanctions at any time before issuing a final decision under § 890.1070.

### § 890.1068 Effect of not contesting proposed penalties and assessments.

(a) *Proposed sanctions may be implemented immediately.* In the absence of a timely response by a provider as required in the notice described in § 890.1066, the debarring official may issue a final decision implementing the proposed financial sanctions immediately, without further procedures.

(b) *Debarring official sends notice after implementing sanctions.* Immediately upon issuing a final decision under paragraph (a), the debarring official must send the provider written notice, via certified return receipt mail or express delivery service, stating:

(1) The amount of penalties and assessments imposed;

(2) The date on which they were imposed; and

(3) The means by which the provider may pay the penalties and assessments.

(c) *No appeal rights.* A provider may not pursue a further administrative or judicial appeal of the debarring official's final decision implementing any sanctions if a timely contest was not filed in response to OPM's notice under § 890.1066.

### § 890.1069 Information the debarring official must consider in deciding a provider's contest of proposed penalties and assessments.

(a) *Documentary material and written arguments.* As part of a provider's contest, the provider must furnish a written statement of reasons why the proposed penalties and assessments should not be imposed and/or why the amounts proposed are excessive.

(b) *Mandatory disclosures.* In addition to any other information submitted during the contest, the provider must inform the debarring official in writing of:

(1) Any existing, proposed, or prior exclusion, debarment, penalty, assessment, or other sanction that was imposed by a Federal, State, or local government agency, including any administrative agreement that purports to affect only a single agency; and

(2) Any current or prior criminal or civil legal proceeding that was based on the same facts as the penalties and assessments proposed by OPM.

(c) *In-person appearance.* A provider may request a personal appearance (in person, by telephone conference, or through a representative) to provide testimony and oral arguments to the debarring official.

### § 890.1070 Deciding contests of proposed penalties and assessments.

(a) *Debarring official reviews entire administrative record.* After the provider submits the information and evidence authorized or required by § 890.1069, the debarring official shall review the entire official record to determine if the contest can be decided without additional administrative proceedings, or if an evidentiary hearing is required to resolve disputed material facts.

(b) *Previously determined facts.* Any facts relating to the basis for the proposed penalties and assessments that were determined in prior due process proceedings are binding on the debarring official in deciding the contest. ''Prior due process proceedings'' are those set forth in § 890.1025(a)(1) through (4).

(c) *Deciding the contest without further proceedings.* To decide the contest without further administrative proceedings, the debarring official must determine that:

(1) The preponderance of the evidence in the administrative record as a whole demonstrates that the provider committed a sanctionable violation described in § 890.1061; and

(2) The evidentiary record contains no *bona fide* dispute of any fact material to the proposed financial sanction. A ''material fact'' is a fact essential to determining whether a provider committed a sanctionable violation for which penalties and assessments may be imposed.

(d) *Final decision without further proceedings.* If the debarring official determines that paragraphs (c)(1) and (c)(2) of this section both apply, a final decision may be issued, imposing financial sanctions in amounts not exceeding those proposed in the notice to the provider described in § 890.1066.

(e) *Insufficient evidence.* If the debarring official determines that a preponderance of the evidence does not demonstrate that the provider committed a sanctionable violation described in § 890.1061, the notice of proposed sanctions described in § 890.1066 must be withdrawn.

(f) *Disputed material facts.* If the debarring official determines that the administrative record contains a *bona fide* dispute about any fact material to the proposed sanction, he must refer the case for a fact-finding hearing to resolve the disputed fact or facts. The provisions of § 890.1027(b) and (c), 890.1028, and 890.1029(a) and (b) will govern such a hearing.

(g) *Final decision after fact-finding hearing.* After receiving the report of the fact-finding hearing, the debarring official must apply the provisions of paragraphs (c), (d), and (e) of this section to reach a final decision on the provider's contest.

### § 890.1071 Further appeal rights after final decision to impose penalties and assessments.

If the debarring official's final decision imposes any penalties and assessments, the affected provider may appeal it to the appropriate United States district court under the provisions of 5 U.S.C. 8902a(h)(2).

### § 890.1072 Collecting penalties and assessments.

(a) *Agreed-upon payment schedule.* At the time OPM imposes penalties and assessments, or the amounts are settled or compromised, the provider must be afforded the opportunity to arrange an agreed-upon payment schedule.

(b) *No agreed-upon payment schedule.* In the absence of an agreed-upon payment schedule, OPM must collect penalties and assessments under its regular procedures for resolving debts owed to the Employees Health Benefits Fund.

(c) *Offsets.* As part of its debt collection efforts, OPM may request other Federal agencies to offset the penalties and assessments against amounts that the agencies may owe to the provider, including Federal income tax refunds.

(d) *Civil lawsuit.* If necessary to obtain payment of penalties and assessments, the United States may file a civil lawsuit as set forth in 5 U.S.C. 8902(i).

(e) *Crediting payments.* OPM must deposit payments of penalties and assessments into the Employees Health Benefits Fund.

## Subpart K—Temporary Continuation of Coverage

SOURCE: 54 FR 52339, Dec. 21, 1989, unless otherwise noted.

### § 890.1101 Purpose.

This subpart identifies the individuals who may temporarily continue coverage after the coverage would otherwise terminate under this part and sets forth the circumstances of their enrollment.

### § 890.1102 Definitions.

In this subpart—

*Gross misconduct* means a flagrant and extreme transgression of law or established rule of action for which an employee is separated and concerning which a judicial or administrative finding of gross misconduct has been made.

*Qualifying event* means any of the following events that qualify an individual for temporary continuation of coverage under subpart K of this part:

(1) A separation from Government service.

(2) A divorce or annulment.

(3) A change in circumstances that causes an individual to become ineligible to be considered a child who is a covered family member under this part.

[54 FR 52339, Dec. 21, 1989, as amended at 78 FR 64878, Oct. 30, 2013]

### § 890.1103 Eligibility.

(a) Except as provided by paragraph (b) of this section, individuals described by this section are eligible to elect temporary continuation of coverage under this subpart. Eligible individuals are as follows:

(1) Former employees whose coverage ends because of a separation from Federal service under any circumstances except an involuntary separation for gross misconduct.

(2) Individuals whose coverage as children under the self plus one or self and family enrollment of an employee, former employee, or annuitant ends because they cease meeting the requirements for being considered covered family members. For the purpose of this section, children who are enrolled under this part as survivors of deceased employees or annuitants are considered to be children under a self plus one or self and family enrollment of an employee or annuitant at the time of the qualifying event.

(3) Former spouses of employees, of former employees having continued self plus one or self and family coverage under this subpart, or of annuitants, if the former spouse would be eligible for continued coverage under subpart H of this part except for failure to meet the requirement of § 890.803(a)(1) or (3) or the documentation requirements of § 890.806(a), including former spouses who lose eligibility under subpart H within 36 months after termination of the marriage because they ceased meeting the requirement of § 890.803(a)(1) or (3).

(b) An individual who is otherwise eligible for benefits under this part (excluding the temporary extension of coverage and conversion privilege set forth in subpart D of this part) is not entitled to continued coverage under this subpart.

[54 FR 52339, Dec. 21, 1989, as amended at 78 FR 64878, Oct. 30, 2013; 80 FR 55737, Sept. 17, 2015]

### § 890.1104 Notification by agency.

(a) In the case of a former employee who is eligible to elect temporary continuation of coverage under § 890.1103(a)(1), the employing office must notify the former employee concerning his or her rights under this subpart no later than 30 days after the end of the temporary extension of coverage provided under § 890.401.

(b)(1) In the case of a child who is eligible to elect temporary continuation of coverage under § 890.1103(a)(2), the enrollee may, within 60 days after the qualifying event, provide written notice to the employing office of the child's change in status and requesting information about temporary continuation of coverage. The written notice must include the child's name and address and the date of the terminating event.

(2) If the notice described in paragraph (b)(1) of this section is received by the employing office within 60 days after the date on which the child ceased meeting the requirements for being considered a covered family member, the employing office must notify the child of his or her rights under this subpart within 14 days after receiving the notice.

(3) This paragraph does not preclude the employing office from notifying the child of his or her rights based on oral or written notification by the child, another family member, or any other source that the child no longer meets the requirements for being considered a covered family member.

(c)(1) In the case of a former spouse who is eligible to elect temporary continuation of coverage under §890.1103(a)(3), the employee or the former spouse may, within 60 days after the termination of the marriage or the loss of coverage under subpart H of this part, notify the employing office of the terminating event and request information about temporary continuation of coverage. The notice must include the name and address of the former spouse and the date of the terminating event.

(2) The employing office must notify the former spouse of his or her rights under this subpart within 14 days after receiving the notice described in paragraph (c)(1) of this section.

(d) If the employing office cannot give the notice required by this section to the employee, child, or former spouse directly, it must send the notice by first class mail. A notice that is mailed is deemed to be received 5 days after the date of the notice.

[54 FR 52339, Dec. 21, 1989, as amended at 57 FR 21192, May 19, 1992; 78 FR 64878, Oct. 30, 2013]

### §890.1105 Initial election of temporary continuation of coverage; application time limitations and effective dates.

(a) The election of temporary continuation of coverage may be in the form of a Standard Form 2809, letter, or written statement to the employing office.

(b) *Former employees.* A former employee's election under this subpart must be submitted to the employing office within 60 days after the later of—

(1) The date of separation; or

(2) The date the former employee received the notice from the employing office.

(c) *Children.* A child's election under this subpart must be submitted to the employing office within 60 days after the later of—

(1) The date of the qualifying event; or

(2) If the employee notified the employing office within the 60-day time period specified under §890.1104(b)(1) of this part, the date the child received the notice from the employing office. If the employee did not notify the employing office within the specified time period, the child's opportunity to elect continued coverage ends 60 days after the qualifying event.

(d) *Former spouses.* (1) A former spouse's election must be received by the employing office within 60 days after the later of—

(i) The date of the qualifying event; or

(ii) The date coverage under subpart H of this part was lost because of remarriage or loss of qualifying court order, if the loss of coverage under subpart H occurred before the expiration of the 36-month period specified in §890.1107(c); or

(iii) If the employee, annuitant, or former spouse notified the employing office of the termination of the marriage within the time period specified in §890.1104(c)(1), the date the former spouse received the notice from the employing office described in §890.1104(c)(2). If the employee, annuitant, or former spouse did not notify the employing office within the specified time period, the former spouse's opportunity to elect continued coverage ends 60 days after the qualifying event.

(2) The effective date of former spouse coverage is the later of—

(i) The date determined under paragraph (g) of this section; or

(ii) The date of the divorce or annulment.

(e) If an individual who is eligible for temporary continuation of coverage under this section is unable to file an

election on his or her own behalf because of a mental or physical disability, an election may be filed by a court-appointed guardian.

(f) *Belated elections.* Except as provided in paragraphs (c)(2) and (d)(1)(iii) of this section, when an employing office determines that an eligible individual was unable, for cause beyond his or her control, to elect temporary continuation of coverage within the time limits prescribed by this section, that office must accept the election within 60 days after it advises the individual of that determination.

(g) *Effective date of coverage.* Except as provided in paragraph (d)(2)(ii) of this section, the effective date of temporary continuation of coverage is the day after other coverage under this part expires, including the 31-day temporary extension of coverage under § 890.401. If an individual elects temporary continuation of coverage after the 31-day temporary extension of coverage expires, but before the expiration of the applicable election period specified in this section, coverage is restored retroactively, with appropriate contributions and claims, to the same extent and effect as though no break in coverage occurred.

[54 FR 52339, Dec. 21, 1989, as amended at 62 FR 38442, July 18, 1997]

### § 890.1106 Coverage.

(a) *Type of enrollment.* An individual who enrolls under this subpart may elect coverage for self only, self plus one, or self and family.

(1) For an enrollee who is eligible for continued coverage under § 890.1103(a)(1) or (2), a covered family member is an individual whose relationship to the enrollee meets the requirements of 5 U.S.C. 8901(5) and who meets any applicable requirements of 5 CFR 890.302 of this part.

(2) For a former spouse who is eligible for continued coverage under § 890.1103(3) of this part, a covered family member is an individual who meets the requirements of § 890.804 of this part.

(b) *Plans and options.* An individual who elects to continue coverage under this subpart may enroll in a plan or option different from the plan or option covering the individual at the time of the qualifying event.

[54 FR 52339, Dec. 21, 1989, as amended at 80 FR 55737, Sept. 17, 2015]

### § 890.1107 Length of temporary continuation of coverage.

(a) In the case of a former employee who is eligible for continued coverage under § 890.1103(a)(1), the temporary continuation of coverage ends on the date that is 18 months after the date of separation, unless it is terminated earlier under the provisions of § 890.1110.

(b)(1) Except as provided in paragraph (b)(2) of this section, in the case of individuals who are eligible for continued coverage under § 890.1103(a)(2), the temporary continuation of coverage ends on the date that is 36 months after the date the individual first ceases to meet the requirements for being considered a child who is a covered family member, unless it is terminated earlier under the provisions of § 890.1110.

(2) The temporary continuation of coverage ends on the date that is 36 months after the date of the separation from service on which the former employee's continuation of coverage is based, unless it is terminated earlier under the provisions of § 890.1110, in the case of individuals who—

(i) Are eligible for continued coverage under § 890.1103(a)(2); and

(ii) As of the day before ceasing to meet the requirements for being considered children who are covered family members, were covered family members of a former employee receiving continued coverage under this subpart; and

(iii) Cease meeting the requirements for being considered children who are covered family members before the end of the 18-month period specified in paragraph (a) of this section.

(c)(1) Except as provided in paragraph (c)(2) of this section, in the case of former spouses who are eligible for continued coverage under § 890.1103(a)(3), the temporary continuation of coverage ends on the date that is 36 months after the former spouse ceased meeting the requirements for coverage as a family member, unless it is terminated earlier under the provisions of § 890.1110.

(2) The temporary continuation of coverage ends on the date that is 36 months after the date of the separation from service on which the former employee's continuation of coverage is based, unless it is terminated earlier under the provisions of § 890.1110, in the case of a former spouse—

(i) Who is eligible for continued coverage under § 890.1103(a)(3); and

(ii) Whose marriage to the former employee terminates after the former employee's separation but before the expiration of the 18-month period specified in paragraph (a) of this section.

[54 FR 52339, Dec. 21, 1989, as amended at 78 FR 64878, Oct. 30, 2013]

### § 890.1108 Opportunities to change enrollment; effective dates.

(a) *Effective date—generally.* Except as otherwise provided, a change of enrollment takes effect on the first day of the first pay period that begins after the date the employing office receives an appropriate request to change the enrollment.

(b) *Belated change of enrollment.* When an employing office determines that an enrollee was unable, for cause beyond his or her control, to change the enrollment within the time limits prescribed by this section, the enrollee may do so within 60 days after the employing office advises the enrollee of its determination.

(c) *Change of enrollment by proxy.* Subject to the discretion of the employing office, an enrollee's representative, having written authorization to do so, may change the enrollment for the enrollee.

(d) *Decreasing enrollment type.* (1) An enrollee may decrease enrollment type at any time.

(2) A decrease in enrollment type takes effect on the first day of the first pay period that begins after the date the employing office receives an appropriate request to change the enrollment, except that at the request of the enrollee and upon a showing satisfactory to the employing office that there was no family member eligible for coverage under the self plus one or self and family enrollment, or only one family member eligible for coverage under the self and family enrollment, as appropriate, the employing office may make the change effective on the first day of the pay period following the one in which there was, in the case of a self plus one enrollment, no family member or, in the case of a self and family enrollment, only one or no family member.

(e) *Open season.* (1) During an open season as provided by § 890.301(f), an enrollee (except for a former spouse who is eligible for continued coverage under § 890.1103(a)(3)) may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes. A former spouse who is eligible for continued coverage under § 890.1103(a)(3) may change from one plan or option to another, but may not increase enrollment type unless the individual to be covered under the self plus one or self and family enrollment qualifies as a family member under § 890.1106(a)(2).

(2) An open season change of enrollment takes effect on the first day of the first pay period that begins in January of the next following year.

(3) When a belated open season change of enrollment is accepted by the employing office under paragraph (b) of this section, it takes effect as required by paragraph (e)(2) of this section.

(f) *Change in family status.* (1) Except for a former spouse, an enrollee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the enrollee's family status changes, including a change in marital status or any other change in family status. The enrollee must change the enrollment within the period beginning 31 days before the date of the change in family status, and ending 60 days after the date of the change in family status.

(2) A former spouse who is covered under this section may increase enrollment type, change from one plan or option to another, or make any combination of these changes within the period beginning 31 days before and ending 60 days after the birth or acquisition of a child who qualifies as a covered family member under § 890.1106(a)(2).

(3) A change of enrollment made in conjunction with the birth of a child,

or the addition of a child as a new family member in some other manner, takes effect on the first day of the pay period in which the child is born or becomes an eligible family member.

(g) *Reenrollment of individuals who lose other coverage under this part.* An individual whose continued coverage under this section terminates because of the provisions of § 890.1110(a)(3) (termination due to other coverage under another provision of this part) may reenroll if the coverage that terminated the enrollment under this part ends, but not later than the expiration of the period described in § 890.1107. Coverage does not extend beyond the expiration of the period described in § 890.1107. The effective date of the reenrollment is the day following the termination of the coverage described in § 890.1110(a)(3).

(h) *Loss of coverage under this part or under another group insurance plan.* An enrollee may decrease or increase enrollment type, change from one plan or option to another, or make any combination of these changes when the enrollee loses coverage under this part or a qualified family member of the enrollee loses coverage under this part or under another group health benefits plan. Except as otherwise provided, an enrollee must change the enrollment within the period beginning 31 days before the date of loss of coverage and ending 60 days after the date of loss of coverage. Losses of coverage include, but are not limited to—

(1) Loss of coverage under another FEHB enrollment due to the termination, cancellation, or change to self plus one or to self only, of the covering enrollment.

(2) Loss of coverage under another federally-sponsored health benefits program.

(3) Loss of coverage due to the termination of membership in an employee organization sponsoring or underwriting an FEHB plan.

(4) Loss of coverage due to the discontinuance of an FEHB plan, in whole or in part. For an enrollee who loses coverage under this paragraph (h)(4)—

(i) If the discontinuance is at the end of a contract year, the enrollee must change the enrollment during the open season, unless OPM establishes a different time. If the discontinuance is at a time other than the end of the contract year, OPM must establish a time and effective date for the enrollee to change the enrollment.

(ii) If the whole plan is discontinued, an enrollee who does not change the enrollment within the time set will be enrolled in the lowest-cost nationwide plan option, as defined in § 890.301(n);

(iii) If one or more options of a plan are discontinued, an enrollee who does not change the enrollment will enrolled in the remaining option of the plan, or in the case of a plan with two or more options remaining, the lowest-cost remaining option that is not a High Deductible Health Plan (HDHP);

(iv) If the discontinuance of the plan, whether permanent or temporary, is due to a disaster, the enrollee must change the enrollment within 60 days of the disaster, as announced by OPM. If the enrollee does not change the enrollment within the time frame announced by OPM, the enrollee will be enrolled in the lowest-cost nationwide plan option, as defined in § 890.301(n). The effective date of enrollment changes under this provision will be set by OPM when it makes the announcement allowing such changes;

(v) An enrollee who is unable, for causes beyond his or her control, to make an enrollment change within the 60 days following a disaster and is, as a result, enrolled in the lowest-cost nationwide plan as defined in § 890.301(n), may request a belated enrollment into the plan of his or her choice subject to the requirements of paragraph (c) of this section.

(5) Loss of coverage under the Medicaid program or similar State-sponsored program of medical assistance for the needy.

(6) Loss of coverage under a non-Federal health plan.

(i) *Move from comprehensive medical plan's area.* An enrollee in a comprehensive medical plan who moves or becomes employed outside the geographic area from which the plan accepts enrollments, or, if already outside this area, moves or becomes employed further from this area, may change the enrollment upon notifying the employing office of the move or

change of place of employment. Similarly, an enrollee whose covered family member moves outside the geographic area from which the plan accepts enrollments, or if already outside this area, moves further from this area, may change the enrollment upon notifying the employing office of the family member's move. The change of enrollment takes effect on the first day of the pay period that begins after the employing office receives an appropriate request.

(j) *On becoming eligible for Medicare.* An enrollee may change the enrollment from one plan or option to another at any time beginning on the 30th day before becoming eligible for coverage under title XVIII of the Social Security Act (Medicare). A change of enrollment based on becoming eligible for Medicare may be made only once.

[62 FR 38442, July 18, 1997, as amended at 72 FR 1912, Jan. 17, 2007; 80 FR 55737, Sept. 17, 2015; 80 FR 65883, Oct. 28, 2015]

### § 890.1109 Premium payments.

(a) Except as provided in paragraph (b) of this section, the enrollee must pay the full enrollment charge as determined under § 890.503(a), including both the Government contributions and employee withholdings, plus the administrative charge described under § 890.1113, for every pay period during which the enrollment continues, exclusive of the 31-day temporary extension of coverage for conversion provided under § 890.401 of this part.

(b) If the enrollee is not covered under this subpart for the full pay period, he or she pays the premium charge for only the days actually covered. The daily premium rate is an amount equal to the monthly rate (including the administrative charge) multiplied by 12 and divided by 365.

(c) The enrollee must make the payment after the pay period during which he or she is covered in accordance with a schedule established by the employing office. If the employing office does not receive the payment by the date due, the employing office must notify the enrollee in writing that continuation of coverage depends upon payment being made within 15 days (45 days for enrollees residing overseas) after receipt of the notice. If no subsequent payments are made, the employing office terminates the enrollment 60 days (90 days for enrollees residing overseas) after the date of the notice. An enrollee whose coverage terminates because of nonpayment may not reenroll or reinstate coverage except as provided under paragraph (d) of this section.

(d)(1) If the enrollee was prevented by circumstances beyond his or her control from making payment within the timeframe specified in paragraph (c) of this section, he or she may request reinstatement of coverage by writing to the employing office. The request must be filed within 30 calendar days from the date of termination and must be accompanied by verification that the enrollee was prevented by circumstances beyond his or her control from paying within the time limit.

(2) The employing office determines whether the individual is eligible for reinstatement of coverage. If the determination is affirmative, coverage is reinstated retroactively to the date of termination. If the determination is negative, the individual may request a review of the decision from the employing agency as provided under § 890.104.

[54 FR 52339, Dec. 21, 1989, as amended at 59 FR 67607, Dec. 30, 1994; 61 FR 37810, July 22, 1996]

### § 890.1110 Termination of enrollment or coverage.

(a) *General.* An enrollment under this subpart terminates at midnight of the earlier of the following dates:

(1) The date the temporary continuation of coverage expires as set forth in § 890.1107, subject to the temporary extension of coverage for conversion.

(2) The last day of the pay period in which the enrollee dies.

(3) The day before the effective date of coverage under another provision of this part.

(4) The date provided under paragraphs (b) or (c) of this section.

(b) *Failure to pay premiums.* Termination of enrollment for failure to pay premiums within the timeframe established under § 890.1109 of this part is retroactive to the end of the last pay period for which payment was timely

received. The enrollee and covered family members, if any, are not entitled to the temporary extension of coverage for conversion or to convert to an individual contract for health benefits.

(c) *Cancellation*. An enrollee may cancel his or her enrollment as provided under § 890.304(d) of this part.

(d) *Family member coverage*. The coverage of a family member terminates under the conditions set forth in § 890.304(c). Covered family members of former employees and former spouses are entitled to temporary continuation of coverage only as set forth under § 890.1103.

### § 890.1111 Employing office responsibilities.

(a) *Providing information to employees*. Employing offices are responsible for providing employees who are eligible to enroll under this part with literature developed by OPM that sets forth their rights under this subpart. This literature must be distributed to employees prior to each open season occurring under § 890.301.

(b) *Administration of the enrollment process*. The employing office must establish procedures for notifying the former employee, child, or former spouse about his or her eligibility to enroll, including what documents are needed to determine eligibility, and for accepting enrollment registrations.

(c) *Collecting premiums*. (1) Collection of the contributions is the responsibility of the employing office of the employee or annuitant at the time of the qualifying event.

(2) The employing office must submit all premium payments collected from enrollees along with its regular health benefits payments to OPM in accordance with procedures established by that Office.

(d) *Health benefits file*. The employing office must maintain a health benefits file for the enrollee as a file separate from the personnel records of the employee or former employee. This file may be destroyed 2 years after the end of the calendar year during which the 18- or 36-month period described in § 890.1107 (a) or (b)(1) expires.

[54 FR 52339, Dec. 21, 1989, as amended at 55 FR 22891, June 5, 1990]

### § 890.1112 Denial of continuation of coverage due to involuntary separation for gross misconduct.

(a) *Notice of denial*. (1) When an employing office determines that the offense for which an employee is being removed constitutes gross misconduct for the purpose of this subpart, the employing office must notify the employee in writing of its intention to deny temporary continuation of coverage. The notice must set forth the reason for the denial and give the employee a reasonable amount of time to respond. The notice must be made no later than the date of separation.

(2) If the employee is being removed under the authority of part 752 of this chapter (or other law, Executive Order, or regulation that prescribes procedures for removing employees because of misconduct), the notification requirement of paragraph (a)(1) of this section may be combined with the notification requirement of such authority.

(b) *Employee's response*. (1) The employee must be allowed a reasonable time for response, but not less than 7 days. The employee may respond orally or in writing and is entitled to be represented by an attorney or other representative.

(2) The agency must designate an official to hear the employee's oral answer who has the authority either to make or recommend a final decision on the denial. The right to answer orally does not include the right to a formal hearing with examination of witnesses.

(c) *Final decision*. If the employee responds to the notice of denial, the employing office must issue a final decision in writing that fully sets forth its findings and conclusions. The agency's decision is not subject to reconsideration by OPM.

(d) *Resignation in lieu of involuntary separation*. If an employee resigns after receiving the employing office's notification of intent to separate the employee involuntarily but before the scheduled separation date, his or her separation is considered involuntary for the purpose of this subpart.

### § 890.1113 The administrative charge.

(a) OPM has determined that the administrative charge as provided under 5 U.S.C. 8905a(d)(1)(A)(ii) is 2 percent of

the enrollment charge described in § 890.503(a).

(b) It is OPM's responsibility to establish procedures for receiving the administrative payment into the Employees Health Benefits Fund and for making this amount available to the employing office.

[54 FR 52339, Dec. 21, 1989, as amended at 55 FR 22891, June 5, 1990]

## Subpart L—Benefits for United States Hostages in Iraq and Kuwait and United States Hostages Captured in Lebanon

SOURCE: 55 FR 50537, Dec. 7, 1990, unless otherwise noted.

### § 890.1201 Purpose.

This subpart sets forth the circumstances under which individuals are covered under this part in accordance with the provisions of section 599C of Public Law 101–513.

### § 890.1202 Definitions.

In this subpart—

*Covered family members* as it applies to individuals covered under this subpart has the same meaning as set forth in § 890.101(a). For eligible survivors of individuals enrolled under this subpart, a self plus one enrollment covers only the survivor or former spouse and one eligible child of both the survivor or former spouse and hostage. A self and family enrollment covers only the survivor or former spouse and any eligible children of both the survivor or former spouse and hostage.

*Hostage* and *hostage status* have the meaning set forth in section 599C of Public Law 101–513.

*Pay period* for individuals enrolled under this subpart means the pay period established by the U.S. Department of State for paying individuals covered under Public Law 101–513.

*Period of eligibility* means the period beginning on the effective date set forth in § 890.1204 of this subpart and ending 60 months after hostage status ended for hostages in Lebanon and 12 months after hostage status ended for hostages in Iraq and Kuwait.

[55 FR 50537, Dec. 7, 1990, as amended at 57 FR 43132, Sept. 18, 1992; 78 FR 64878, Oct. 30, 2013; 80 FR 55738, Sept. 17, 2015]

### § 890.1203 Coverage.

(a) An individual is covered under this subpart when the U.S. Department of State determines that the individual is eligible for coverage under section 599C of Public Law 101–513.

(b) An individual who is covered under this subpart is covered under the Standard Option of the Service Benefit Plan. The individual has a self and family enrollment unless the U.S. Department of State determines that the individual is married and has no eligible children, or is unmarried and has one eligible child, in which case the individual is covered under a self plus one enrollment, or unless the U.S. Department of State determines that the individual is unmarried and has no eligible children, in which case the individual has a self only enrollment.

(c) Individuals covered under this subpart are deemed ineligible for enrollment in any FEHB plan or option other than the Standard Option of the Service Benefit Plan.

(d) Eligible surviving family members of an individual covered under this subpart whose hostage status ended because of death or who dies during the 60 months or 12 months following the end of hostage status are eligible to continue enrollment under this part. The enrollment terminates no later than 60 months or 12 months after hostage status ended.

(e) An individual covered by this subpart is not considered an employee for the purpose of this part.

(f) Eligibility for coverage under this subpart shall be subject to the availability of funds under section 599C(e) of Public Law 101–513.

[55 FR 50537, Dec. 7, 1990, as amended at 57 FR 43132, Sept. 18, 1992; 78 FR 64878, Oct. 30, 2013; 80 FR 55738, Sept. 17, 2015]

### § 890.1204 Effective date of coverage.

Unless the U.S. Department of State determines that a later date is appropriate, coverage under § 890.1203(b) is effective on August 2, 1990, for hostages in Iraq and Kuwait and on the later of

the date hostage status began or June 1, 1982, for hostages in Lebanon.

[57 FR 43132, Sept. 18, 1992]

### § 890.1205 Change in type of enrollment.

(a) Individuals covered under this subpart or eligible survivors enrolled under this subpart may increase enrollment type if they acquire an eligible family member. The change may be made at the written request of the enrollee at any time after the family member is acquired. An increase in enrollment type under this paragraph (a) becomes effective on the 1st day of the pay period after the pay period during which the request is received by the U.S. Department of State, except that a change based on the birth or addition of a child as a new family member is effective on the 1st day of the pay period during which the child is born or otherwise becomes a new family member.

(b) Individuals covered under this subpart or eligible survivors enrolled under this subpart may decrease enrollment type from a self and family enrollment when the last eligible family member (other than the enrollee) ceases to be a family member or only one family member remains; and may decrease enrollment type from a self plus one enrollment when no family member remains. The change may be made at the written request of the enrollee at any time after the last family member is lost and it becomes effective on the 1st day of the pay period after the pay period during which the request is received by the U.S. Department of State.

(c) A family member may file a request to change the type of enrollment on behalf of a hostage during the period of hostage status or on behalf of an eligible former hostage who cannot file the election on his or her own behalf because of a mental or physical disability.

[55 FR 50537, Dec. 7, 1990, as amended at 80 FR 55738, Sept. 17, 2015]

### § 890.1206 Cancellation of coverage.

(a) An individual who is covered under § 890.1203(b) may cancel his or her enrollment at any time by written request. The cancellation is effective on the 1st day of the pay period after the pay period in which it is received by the U.S. Department of State.

(b) An individual who cancels his or her coverage under this section cannot reacquire coverage unless the U.S. Department of State determines that it would be against equity and good conscience not to allow the individual to be enrolled.

(c) A cancellation of coverage must be made by the enrolled individual and cannot be made by a representative acting on the individual's behalf.

### § 890.1207 Termination of coverage.

(a) Coverage of an individual under § 890.1203(b) terminates 60 months or 12 months after hostage status ended unless the individual cancels the coverage earlier.

(b) Enrollees and family members are eligible for temporary extension of coverage for conversion as set forth in subpart D of this part unless the covering enrollment is terminated by cancellation.

[55 FR 50537, Dec. 7, 1990, as amended at 57 FR 43132, Sept. 18, 1992]

### § 890.1208 Premiums.

(a) Government and employee contributions (premiums) required under §§ 890.501 and 890.502 of this part are paid from the appropriation provided under section 599C(e) of Public Law 101–513.

(b) If the individual is not covered under this subpart for the full pay period, premiums are paid only for the days he or she is actually covered. The daily premium rate is an amount equal to the monthly premium rate multiplied by 12 and divided by 365.

(c) The payments required by this section may be accepted by OPM from the State Department appropriation in advance if necessary to fund the 12-month period of coverage beginning on the earlier of:

(1) The day after sanctions or hostilities end; or

(2) The day after the individual's period of hostage status ends.

(d) OPM will place any funds received under paragraph (c) of this section in

an account established for this purpose. OPM will make the disbursements specified under 48 CFR subpart 1632.170 from this account when the appropriate pay period occurs.

[55 FR 50537, Dec. 7, 1990, as amended at 57 FR 14325, Apr. 20, 1992]

### § 890.1209 Responsibilities of the U.S. Department of State.

(a) The U.S. Department of State functions as the ''employing office'' for individuals covered under this subpart.

(b) The U.S. Department of State must determine the eligibility of individuals who qualify under Public Law 101–513 for coverage under this part. This determination includes the determination as to whether the individual is barred from coverage under chapter 89 of title 5 U.S. Code by reason of other health insurance coverage as provided in section 599C of Public Law 101–513.

(c) The U.S. Department of State must determine the number of eligible family members, if any, for the purpose of coverage under a self only, self plus one, or self and family enrollment as set forth in § 890.1203(b). If the number of eligible family members of the individual cannot be determined, the U.S. Department of State must enroll the individual for self and family coverage.

[55 FR 50537, Dec. 7, 1990, as amended at 80 FR 55738, Sept. 17, 2015]

### § 890.1210 Reconsideration and appeal rights.

(a) Under procedures set forth by the U.S. Department of State, an individual may request the U.S. Department of State to reconsider an initial decision it has made denying coverage or a change in the type of enrollment under this subpart.

(b) Neither the initial decision nor the reconsideration decision of the U.S. Department of State is subject to reconsideration by OPM.

## Subpart M—Department of Defense Federal Employees Health Benefits Program Demonstration Project

SOURCE: 65 FR 35260, June 2, 2000, unless otherwise noted.

### § 890.1301 Purpose.

The purpose of this subpart is to implement section 721 of the National Defense Authorization Act for 1999, Public Law 105–261. This section amended chapter 55 of title 10, United States Code, and chapter 89 of title 5, United States Code, to establish a demonstration project under which certain Medicare and other eligible Department of Defense (DoD) beneficiaries can enroll in health benefit plans offered under the Federal Employees Health Benefits (FEHB) Program in certain geographic areas. The legislation was signed into law on October 17, 1998. The demonstration project will run for a period of three years. The legislation requires the Office of Personnel Management (OPM) and DoD to jointly produce and submit two reports to Congress designed to assess the viability of expanding access to the FEHB Program to certain Medicare and other eligible DoD beneficiaries permanently. OPM is authorizing certain differences from regular FEHB Program practices in order to ensure the successful implementation of the demonstration project. This regulation authorizes those differences.

### § 890.1302 Duration.

The demonstration project will run from January 1, 2000, through December 31, 2002.

### § 890.1303 Eligibility.

(a) To enroll in the demonstration project, an individual must live within one of the demonstration areas and meet the definition of an eligible beneficiary in 10 U.S.C. 1108(b). An eligible beneficiary under this subpart is—

(1) A member or former member of the uniformed services described in section 1074(b) of title 10, United States Code, who is entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c *et seq.*);

(2) An individual who is an unremarried former spouse of a member or former member described in section 1072(2)(F) or section 1072(2)(G) of title 10, United States Code;

(3) An individual who is—

(i) A dependent of a deceased member or former member described in section

1076(b) or 1076(a)(2)(B) of title 10, United States Code, or of a member who died while on active duty for a period of more than 30 days; and

(ii) A ''member of family'' as defined in section 8901(5) of title 5, United States Code; or

(4) An individual who is—

(i) A dependent of a living member or former member described in section 1076(b)(1) of title 10, United States Code, who is entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act, regardless of the member's or former member's eligibility for such hospital insurance benefits; and

(ii) A ''member of family'' as defined in section 8901(5) of title 5, United States Code.

(b) An eligible beneficiary may enroll in an FEHB plan under chapter 89 of title 5, United States Code, for self-only coverage or for self and family coverage. A self and family enrollment will include coverage of a dependent of the military member or former member who meets the definition of a ''member of family'' in section 8901(5) of title 5, United States Code. A self and family enrollment will not cover a person related to the eligible beneficiary that does not qualify as a ''member of family'' (as defined in section 8901(5) of title 5, United States Code) of the military member or former member.

(c) A person eligible for coverage under this subpart shall not be required to satisfy any eligibility criteria specified in chapter 89 of title 5, United States Code, or in other subparts of this part (except as provided in paragraphs (a)(3), (a)(4), and (b) of this section) as a condition for enrollment in health benefit plans offered through the FEHB Program under the demonstration project.

(d) When determining whether an individual is a ''member of family'' under section 8901(5) of title 5, United States Code, for purposes of paragraph (a)(3) and (a)(4) of this section, a DoD member or former member described in section 1076(b) or 1076(a)(2)(B) of title 10, United States Code, shall be deemed to be an employee under chapter 89 of title 5, United States Code. The sole purpose for deeming these members or former members of the uniformed services employees under chapter 89 of title 5, United States Code, is to determine which of their dependents can enroll as eligible beneficiaries in the demonstration project.

(e) A person who is eligible to enroll in the FEHB Program as an employee as defined in section 8901(1) of title 5, United States Code, is not eligible to enroll in an FEHB plan under the demonstration project.

### § 890.1304 Enrollment.

(a) Open Season for eligible beneficiaries will be held concurrent with the Open Season for regular FEHB enrollees. Open Seasons will be held in the years 1999, 2000 and 2001. Eligible beneficiaries will be able to enroll for coverage, change enrollment tiers (e.g., self-only or self and family), or change health benefit plans or plan options during these periods.

(b) Enrolled eligible beneficiaries are required to pay associate membership dues if they enroll in open employee organization sponsored plans that are participating in the demonstration project.

(c) DoD will deny enrollment of eligible beneficiaries when the total number of eligible beneficiaries and family members enrolled in the demonstration project reaches 66,000.

(d) Eligible beneficiaries can enroll only in health plans offered by health benefit carriers who are participating in the demonstration project.

(e) Eligible beneficiaries and family members enrolled in the demonstration project are not eligible to obtain services from military medical treatment facilities or to enroll in a health care plan under the TRICARE Program.

(f) An eligible beneficiary enrolled in an FEHB plan under the demonstration project may change health benefits plans and coverage in the same manner as any other FEHB Program enrollee, except as provided for in this subpart.

### § 890.1305 Termination and cancellation.

(a) If an enrolled eligible beneficiary moves out of a demonstration area, the enrollment of the eligible beneficiary

and all family members will be terminated. If an enrolled eligible beneficiary moves to an area located within a demonstration area, he or she will continue to be eligible to participate in the demonstration project. If the eligible beneficiary was enrolled prior to the move in an HMO that does not serve the new demonstration area, the eligible beneficiary will have an opportunity to select a new health plan offered by a carrier participating in the demonstration project in the new area. If the eligible beneficiary was enrolled in a fee-for-service plan prior to the move and moves to another area that is within an existing demonstration area, the eligible beneficiary can maintain his or her current coverage.

(b) If an enrolled eligible beneficiary disenrolls, cancels, or terminates enrollment for any reason, he or she will not be eligible to reenroll in the demonstration project. Once coverage ends, eligible beneficiaries and all family members have the right to resume all of the benefits to which they are entitled to under title 10 of the United States Code. Medicare-covered eligible beneficiaries and their eligible family members who had Medigap policies prior to their enrollment in the demonstration project are entitled to reinstate that coverage under the conditions stated in section 1108(l) of title 10, United States Code.

(c) Eligible beneficiaries and their family members are eligible for Temporary Continuation of Coverage (TCC) under the conditions and for the durations described in subpart K or until the end of the demonstration project, whichever occurs first. The effective date of TCC for eligible beneficiaries or their eligible family members will be the day after other coverage under this subpart ends. Eligible beneficiaries or their eligible family members selecting TCC must enroll in a health plan offered by a carrier participating in the demonstration project. If an eligible beneficiary or eligible family member enrolled in DoD TCC moves from a demonstration project area, coverage ends. DoD TCC enrollees will be responsible for paying the entire DoD premium rate (OPM's approved net-to-carrier DoD rate plus 4 percent for contingency and administration reserves) plus 2 percent of this premium rate for administration of the program. DoD will make arrangements to collect premiums plus the 2 percent administrative charge from eligible beneficiaries and forward them to OPM's Employees Health Benefits Fund. OPM will establish procedures for receiving the 2 percent administrative payment into the Employees Health Benefits Fund and making this amount available to DoD for administration of the program.

(d) Enrolled eligible beneficiaries are not eligible for the temporary extension of coverage and conversion opportunities described in subpart D of this part.

### § 890.1306 Government premium contributions.

The Secretary of Defense is responsible for the government contribution for enrolled eligible beneficiaries and family members. The government contribution toward demonstration project premium rates will be determined in accordance with subpart E of this part.

### § 890.1307 Data collection.

Each carrier will compile, maintain, and when requested by OPM or DoD, report data on its plan's experience necessary to produce reports containing the following information and analysis:

(a) The number of eligible beneficiaries who elect to participate in the demonstration project.

(b) The number of eligible beneficiaries who elected to participate in the demonstration project and did not have Medicare Part B coverage before electing to participate.

(c) The costs of health benefits charges and the costs (direct and indirect) of administering the benefits and services provided to eligible beneficiaries who elect to participate in the demonstration project as compared to similarly situated enrollees in the FEHB Program.

(d) Prescription drug costs for demonstration project beneficiaries.

### § 890.1308 Carrier participation.

(a) All carriers who participate in the FEHB Program and provide benefits to

enrollees in the geographic areas selected as demonstration project areas must participate in the demonstration project, except as provided for in paragraphs (b), (c), and (d) of this section.

(b) Carriers who have less than 300 FEHB enrollees may, but are not required to, participate in the demonstration project.

(c) Carriers may, but are not required to, participate in the demonstration project if their service area overlaps a small portion (as determined by OPM) of a demonstration project geographic area.

(d) Carriers offering fee-for-service plans with enrollment limited to specific groups will not participate in the demonstration project.

## Subpart N—Federal Employees Health Benefits For Employees of Certain Indian Tribal Employers

SOURCE: 81 FR 95405, Dec. 28, 2016, unless otherwise noted.

### § 890.1401 Purpose.

This subpart sets forth the conditions for coverage, rights, and benefits under Chapter 89 of title 5, United States Code, according to the provisions of 25 U.S.C. 1647b.

### § 890.1402 Definitions and deemed references.

(a) In this subpart—

*Billing unit* is a subdivision of the tribal employer's workforce that aligns tribal employees for purposes of administering FEHB enrollment and collection of payment. A billing unit may be either governmental or commercial or a combination of both. So long as a tribal employer purchases FEHB for at least one billing unit that is carrying out at least one program under ISDEAA or IHCIA, the tribal employer may purchase FEHB for other billing units without regard to its programs.

*Pay period i*s the interval of time for which a paycheck is issued by the tribal employer for work performed by the tribal employee.

*Paymaster* is the entity designated by OPM as responsible for receiving FEHB premiums from the tribal employer, forwarding premiums to the Employees Health Benefits Fund, and maintaining enrollment records for all participating tribal employers.

*Payment* is the sum of the tribal employer's share of premium plus the tribal employees' share of premium plus any administrative fees or costs required under this subpart, due for the enrollment, in the aggregate, of the tribal employer's tribal employees.

*Tribal employee* is a full-time or part-time common law employee of a tribal employer. An individual is a common law employee if, based on all the facts and circumstances, the tribal employer has the right to control and direct the individual who performs the services, not only as to the result to be accomplished by the work but also as to the details and means by which that result is accomplished. This determination is based on all facts and circumstances and shall be guided by the factors described by the Internal Revenue Service in Rev. Rul. 87–41, 1987–1 C.B. 296 and referenced in Joint Committee on Taxation report JCX–26–07 *Present Law and Background Relating to Worker Classification for Federal Tax Purposes*, dated May 7, 2007, and the determination shall be consistent with the tribal employer's determination of common law employee status for Federal employment tax purposes, if any. For purposes of this subpart, tribal employees do not include retirees or annuitants of a tribal employer, volunteers of a tribal employer, or others who are not common law employees of a tribal employer. Categories of excluded tribal employees are described at § 890.1405(b). FEHB benefits available to tribal employees are set forth in this subpart and to the extent there exists any ambiguity or inconsistency between this subpart and other subparts of part 890, the terms of this subpart will govern FEHB benefits available to tribal employees.

*Tribal employer* is an Indian tribe or tribal organization (as those terms are defined in 25 U.S.C. Chapter 18, ''Indian Health Care'') carrying out at least one program under the Indian Self-Determination and Education Assistance Act or an urban Indian organization (as that term is defined in 25 U.S.C. Chapter 18, ''Indian Health Care'') carrying out at least one program under the

title V of the Indian Health Care Improvement Act, provided that the tribe, tribal organization, or urban Indian organization certifies entitlement to purchase FEHB according to the process described in Subpart N. FEHB benefits that tribal employers are entitled to purchase for their tribal employees are set forth in this subpart and to the extent there exists any ambiguity or inconsistency between this subpart and other subparts of part 890, the terms of this subpart will govern FEHB benefits available for purchase by tribal employers.

(b) In this subpart, wherever reference is made to other subparts of part 890—

(1) A reference to employee is deemed a reference to tribal employee;

(2) A reference to employer is deemed a reference to tribal employer;

(3) A reference to enrollee is deemed a reference to a tribal employee in whose name the enrollment is carried;

(4) A reference to employing agency, employing office, or agency is deemed a reference to tribal employer, and/or if the reference involves the subject of a paymaster function, the paymaster, as appropriate;

(5) A reference to United States, Federal Government, or Government in the capacity of an employer is deemed a reference to tribal employer;

(6) A reference to Federal Service or Government Service is deemed a reference to employment with a tribal employer;

(7) A reference to annuitant, survivor annuitant, or an individual with entitlement to an annuity is deemed inapplicable in the context of this subpart; and

(8) A reference incorporated into this subpart that does not otherwise apply to tribal employees and tribal employers shall have no meaning and is deemed inapplicable in the context of this subpart.

### § 890.1403 Tribal employer purchase of FEHB requires current deposit of premium payment and timely payment of administrative fee.

(a) A tribal employer shall be entitled to purchase coverage, rights, and benefits for its tribal employees under Chapter 89 of title 5, United States Code, if premium payment for the coverage, rights, and benefits for the period of employment with such tribal employer is currently deposited in the Employees Health Benefits Fund, and if the administrative fee is timely paid to the paymaster.

(b) Premium payment will be considered currently deposited if received by the Employees Health Benefits Fund before, during, or within fourteen days after the end of the month covered by the premium payment.

(c) Administrative fee will be considered timely paid if received by the paymaster before, during, or within fourteen days after the end of the month covered by the administrative fee.

(d) Purchase of FEHB coverage by a tribal employer confers all the rights and benefits of FEHB as set forth in Subpart N to the tribal employer and tribal employee.

### § 890.1404 Tribal employer election and agreement to purchase FEHB.

(a) A tribal employer that intends to purchase FEHB for its tribal employees shall notify OPM by email or telephone.

(1) A tribal employer must purchase FEHB for at least one billing unit carrying out programs or activities under the tribal employer's ISDEAA or IHCIA contract.

(2) For so long as a tribal employer continues to purchase FEHB for at least one billing unit carrying out programs or activities under a tribal employer's ISDEAA or IHCIA contract, the tribal employer may purchase FEHB for one or more billing units without regard to whether they are carrying out programs or activities under the tribal employer's ISDEAA or IHCIA contract.

(b) A tribal employer must enter into an agreement with OPM to purchase FEHB. This agreement will include—

(1) The name, job title, and contact information of the individual responsible for health insurance coverage decisions for the tribal employer;

(2) The date on which the tribal employer will begin to purchase FEHB coverage;

(3) The approximate number of tribal employees who will be eligible to enroll;

(4) A certification that the eligible tribal employees within the enrolling billing unit will not have alternate tribal employer-sponsored health insurance coverage available concurrent with FEHB;

(5) A certification and documentation demonstrating that the tribal employer is entitled to purchase FEHB as either: An Indian tribe or tribal organization carrying out at least one program under the Indian Self-Determination and Education Assistance Act; or an urban Indian organization carrying out at least one program under title V of the Indian Health Care Improvement Act;

(6) Agreement by the tribal employer that its purchase of FEHB makes the tribal employer responsible for administering the program in accordance with this subpart, subject to Federal Government audit with respect to such purchase and administration, and subject to OPM authority to direct the administration of the program, including but not limited to the correction of errors;

(7) Agreement that the tribal employer will establish or identify an independent dispute resolution panel to adjudicate appeals of determinations made by a tribal employer regarding an individual's status as a tribal employee eligible to enroll in FEHB, eligibility of family members, and eligibility to change enrollment. This panel must have authority to enforce eligibility decisions;

(8) A certification that the tribal employer will supply necessary enrollment information and payment to the paymaster;

(9) Agreement to provide notice to OPM in the event that the tribal employer is no longer carrying out at least one program under the ISDEAA or title V of IHCIA; and

(10) Other terms and conditions as appropriate.

(c) A tribal employer may make an initial election to purchase FEHB at any time. A tribal employer purchasing FEHB shall commit to purchase FEHB for at least the remainder of the calendar year in which the agreement is signed. Elections will be automatically renewable year to year unless revoked by the tribal employer or terminated by OPM.

(d) If a tribal employer revokes the initial election, OPM must be given 60 days notice. The tribal employer may not re-elect to purchase FEHB until the first annual open season that falls at least twelve months after the revocation. If the tribal employer revokes an election to participate a second time, the tribal employer may not re-elect to purchase FEHB until the first open season that falls at least twenty-four months after the second revocation.

(e) OPM maintains final authority, in consultation with the United States Department of the Interior and the United States Department of Health and Human Services, to determine whether a tribal employer is entitled to purchase FEHB as either—

(1) An Indian tribe or tribal organization carrying out at least one program under the Indian Self-Determination and Education Assistance Act; or

(2) An urban Indian organization carrying out at least one program under title V of the Indian Health Care Improvement Act.

(f) If a tribe, tribal organization or urban Indian organization believes it has been improperly denied the entitlement to purchase FEHB, it may appeal the denial to OPM. The appeal will be given an independent level of review within OPM and the decision on review will be final.

### § 890.1405 Tribal employees eligible for enrollment.

(a) A tribal employee who is a full-time or part-time common law employee of a tribal employer is eligible to enroll in FEHB if that tribal employer has elected to purchase FEHB coverage for the tribal employees of that tribal employer's billing unit, except that a tribal employee described in paragraph (b) of this section is not eligible to enroll in FEHB.

(b) Status as a tribal employee under § 890.1402(a) for purposes of eligibility to enroll in FEHB is initially made based on a reasonable determination by the tribal employer. OPM maintains final authority to correct errors regarding FEHB enrollment as set forth at § 890.1406.

(c) Retirees, annuitants, volunteers, compensationers under Federal worker's disability programs past 365 days, and others who are not common law employees of the tribal employer are not eligible to enroll under this subpart.

(d) The following tribal employees are not eligible to enroll in FEHB—

(1) A tribal employee whose employment is limited to one year or less and who has not completed one year of continuous employment, including any break in service of 5 days or less;

(2) A tribal employee who is expected to work less than 6 months in one year;

(3) An intermittent tribal employee—a non-full-time tribal employee without a prearranged regular tour of duty;

(4) A beneficiary or patient employee in a Government or tribal hospital or home; and

(5) A tribal employee paid on a piecework basis, except one whose work schedule provides for full-time service or part-time service with a regular tour of duty.

(e) Notwithstanding paragraphs (d)(1), (2), and (3) of this section a tribal employee working on a temporary appointment, a tribal employee working on a seasonal schedule of less than 6 months in a year, or a tribal employee working on an intermittent schedule, for whom the tribal employer expects the total hours in pay status (including overtime hours) plus qualifying leave without pay hours to be at least 130 hours per calendar month, is eligible to enroll in FEHB according to terms described in §890.102(j) unless the tribal employer provides written notification to the Director as described in §890.102(k).

(f) The tribal employer initially determines eligibility of a tribal employee to enroll in FEHB, eligibility of family members, and eligibility of tribal employee to change enrollment. The tribal employer's initial decision may be appealed pursuant to §890.1415.

(g) A tribal employee who is eligible and enrolls in FEHB under this subpart will have the option of enrolling in any FEHB open fee-for-service plan or health maintenance organization (HMO), consumer driven health plan (CDHP), or high deductible health plan (HDHP) available to Federal employees in the same geographic location as the tribal employee. The tribal employee will have the same choice of self only, self plus one, or self and family enrollment as is available to Federal employees.

(h) Family members of tribal employees will be covered by FEHB according to terms described at §890.302. Children of tribal employees, whether married or not married, and whether or not dependent, are covered under a self and family enrollment or a self plus one enrollment (if the child is the designated covered family member) up to the age of 26. Former spouses of tribal employees are not former spouses as described at 5 U.S.C. 8901(10) and are not eligible to elect coverage under subpart H.

(i) Eligibility for FEHB under this subpart does not identify an individual as a Federal employee for any purpose, nor does it convey any additional rights or privileges of Federal employment.

### §890.1406 Correction of enrollment errors.

Correction of errors regarding FEHB enrollment for tribal employees takes place according to the terms described in §890.103.

### §890.1407 Enrollment process; effective dates.

(a) *FEHB election for tribal employers.* Tribal employers may purchase FEHB coverage for their tribal employees after an agreement is accepted by OPM. Tribal employers will not be permitted to access FEHB if the tribal employer contributes toward, or offers, an alternative employer-sponsored health insurance plan for tribal employees within the billing unit(s) for which the employer seeks to purchase FEHB coverage, with the exception of a collectively bargained alternative plan. A stand-alone dental, vision, or disability plan is not considered alternative health insurance.

(b) Opportunities for tribal employees to enroll—

(1) Upon electing to purchase FEHB, a tribal employer will establish an initial enrollment opportunity for tribal

employees. A tribal employee's enrollment upon an initial enrollment opportunity becomes effective as prescribed by OPM.

(2) After the initial enrollment opportunity, described in § 890.1407(b)(1), tribal employees are subject to the same initial enrollment period, belated enrollment rules, enrollment by proxy, and open season as Federal employees, as described at § 890.301(a), (b), (c), and (f).

(3) A tribal employee who enrolls after the initial enrollment opportunity and who does not elect premium conversion through his or her tribal employer's premium conversion plan, if one is available, will be subject to the enrollment and qualifying life event rules described at § 890.301 and effective dates described at § 890.301(b) and (f).

(4) A tribal employee who enrolls after the initial enrollment opportunity and who elects premium conversion through his or her tribal employer's premium conversion plan, if one is available, will be subject to the enrollment rules, qualifying life event rules and effective dates described at §§ 892.207, 892.208 and 892.210 of this chapter (together with § 890.301 as referenced therein).

### § 890.1408 Change in enrollment type, plan, or option.

(a) A tribal employee enrolled under this subpart may increase or decrease his or her enrollment, or may change enrollment from one plan or option to another, as described in § 890.301 (for tribal employees who did not elect premium conversion) or part 892 of this chapter (for tribal employees who did elect premium conversion).

(b) A change in enrollment type, plan, or option under this section becomes effective as described in § 890.301 (for tribal employees who did not elect premium conversion) or part 892 of this chapter (for tribal employees who did elect premium conversion).

### § 890.1409 Cancellation of coverage or decreases in enrollment.

(a) A tribal employee enrolled under this subpart may cancel enrollment as described at § 890.304(d) or decrease his or her enrollment as described at § 890.301. A tribal employee who does not participate in premium conversion may cancel his or her enrollment or decrease his or her enrollment at any time by request to the tribal employer, unless there is a legally binding court or administrative order requiring coverage of a child as described at § 890.301(g)(3). A tribal employee who participates in premium conversion may cancel his or her enrollment as provided by § 892.209 or decrease his or her enrollment as provided by § 892.208 of this chapter only during open season or because of and consistent with a qualifying life event.

(b) A cancellation of enrollment becomes effective as described at § 890.304(d). A decrease in enrollment becomes effective as described in § 890.301(e)(2).

(c) A tribal employee who cancels his or her enrollment under this section or decreases his or her enrollment may reenroll or increase his or her enrollment only during open season or because of and consistent with a qualifying life event.

### § 890.1410 Termination of enrollment and 31-day temporary extension of coverage; and conversion to individual policy.

(a) Tribal Employee Separation—

(1) Enrollment of a tribal employee under this subpart terminates due to separation from employment with the tribal employer for reasons of resignation, dismissal, or retirement. Termination of enrollment is effective at midnight of the last day of the pay period in which the tribal employee separates from employment.

(2) A former tribal employee who is separated under this subpart due to resignation, dismissal, or retirement and covered family members are entitled to a 31-day temporary extension of coverage without premium contribution and may convert to an individual policy as described at § 890.401.

(b) Death of tribal employee—

(1) Enrollment of a tribal employee terminates at midnight of the last day of the pay period in which the tribal employee dies.

(2) If, at the time of death, the deceased tribal employee was enrolled in self and family FEHB coverage:

(i) The surviving spouse is entitled to a 31-day temporary extension of coverage without premium contribution and may convert to an individual policy as described at § 890.401;

(ii) The covered children of the deceased tribal employee are entitled to a 31-day temporary extension of coverage without premium contribution and may convert to an individual policy as described at § 890.401.

(3) If, at the time of death, the deceased tribal employee was enrolled in self plus one FEHB coverage, only the designated covered family member is entitled to a 31-day temporary extension of coverage without premium contribution and may convert to an individual policy as described at § 890.401.

(c) Termination of family member coverage—

(1) Coverage of a family member of a tribal employee who was covered under this subpart terminates, subject to the 31-day temporary extension of coverage, for conversion, at midnight of the earlier of the following dates:

(i) The day on which he or she ceases to be a family member; or

(ii) The day the tribal employee's enrollment terminates, unless the family member is entitled to continued coverage under the enrollment of another.

(2) Family members who lose coverage under this subsection are entitled to a 31-day temporary extension of coverage without premium contribution and may convert to an individual policy as described at § 890.401.

(d) Tribal employer loses entitlement to purchase FEHB—

(1) Coverage of a tribal employee and family members under this subpart, except TCC that is already elected and in effect, terminates at midnight of the last day of the calendar year in which a tribal employer is no longer entitled to purchase FEHB. FEHB can terminate earlier at the request of the tribal employer.

(2) Following the termination described in § 890.1410(d)(1), enrolled tribal employees and covered family members are entitled to a 31-day temporary extension of coverage without premium contribution and may convert to an individual policy as described at § 890.401.

(e) Tribal employer revokes election to purchase FEHB—

(1) If a tribal employer voluntarily revokes its election to purchase FEHB, tribal employees will be entitled to a 31-day temporary extension of coverage and may convert to an individual policy as described at § 890.401. In such a case, the FEHB enrollment terminates effective the first day for which premium payment is not received and the 31-day temporary extension of coverage, for conversion begins immediately thereafter.

(2) [Reserved]

(f) Failure to currently deposit premium payment—

(1) If premium payment is not currently deposited in the Employees Health Benefits Fund, the tribal employer's entitlement to purchase FEHB can be terminated, and all enrollments affected by the paymaster's failure to obtain current deposit of premium payment will be terminated, for non-payment.

(2) Enrollments of all of the tribal employer's tribal employees affected by the paymaster's failure to obtain current deposit of premium payment will be terminated effective midnight of the last day of the month for which payment was received.

(3) In the case of termination of enrollment due to non-payment, affected tribal employees will be entitled to a 31-day temporary extension of coverage without premium contribution and may convert to an individual policy as described at § 890.401. The 31-day extension of coverage begins immediately upon termination of enrollment.

(4) In the event that a tribal employer elects to purchase FEHB for its tribal employees but does not currently deposit premium payment in the first month that it is due, the enrollment of tribal employees affected by the paymaster's failure to obtain current deposit of premium payment will be terminated effective midnight of the last day of the month for which premium payment was not currently deposited. Tribal employees affected by the paymaster's failure to obtain current deposit of premium payment will not be entitled to a 31-day temporary extension of coverage and may not convert to an individual policy as described at § 890.401.

(5) Any outstanding premium due for coverage in arrears will be treated as a debt owed solely by the tribal employer.

### § 890.1411 Temporary Continuation of Coverage (TCC).

(a) For purposes of this subpart, temporary continuation of coverage (TCC) is described by 5 U.S.C. 8905a and subpart K of this part. The administrative fee for TCC for tribal employees is the same as for Federal employees, with no specific tribal administrative fee as described in § 890.1413(e).

(b) A former tribal employee who is separated under this subpart due to resignation, dismissal, or retirement may elect TCC, unless the separation is due to gross misconduct as defined in § 890.1102.

(c) Eligibility for TCC for tribal employees follows procedures provided in § 890.1103 of subpart K of this part, except that former spouses of tribal employees are not eligible for TCC.

### § 890.1412 Non-pay status, insufficient pay, or change to ineligible position.

(a) *Non-pay status for 365 days.* Enrollment of a tribal employee and coverage of family members may continue for up to 365 days during which the tribal employee is in a non-pay status (as described at § 890.303(e)(1)) under terms described at § 890.502(b). Enrollment terminates at midnight of the last day of the pay period which includes the 365th consecutive day of nonpay status or the last day of leave under the Family and Medical Leave Act, whichever is later. The tribal employee and covered family members are entitled to a 31-day temporary extension of coverage without premium contribution and may convert to an individual policy as described at § 890.401.

(b) *Insufficient pay.* If the pay of a non-temporary tribal employee who is enrolled in FEHB is insufficient to pay for the tribal employee's share of premiums, the tribal employer must follow the procedure described at § 890.502(b). If the enrollment is terminated due to insufficient pay, the tribal employee and covered family members are entitled to a 31-day temporary extension of coverage without premium contribution and may convert to an individual policy as described at § 890.401.

(c) *Insufficient pay for temporary tribal employees.* If the pay of a temporary tribal employee who meets eligibility requirements described at 5 U.S.C. 8906a is insufficient to pay the tribal employee's share of premiums as described at § 890.304(a)(2), and the tribal employee does not or cannot elect a plan at a cost to him or her not in excess of the pay, the tribal employee's enrollment must be terminated as described at § 890.304(a)(2). The tribal employee and covered family members are entitled to a 31-day temporary extension of coverage without premium contribution and may convert to an individual policy as described at § 890.401.

(d) *Change to ineligible position.* A tribal employee who moves from an FEHB eligible to a non-FEHB-eligible position at a tribal employer will be eligible to continue FEHB enrollment as described in § 890.303(b).

(e) Non-pay status due to Uniformed Service—

(1) Enrollment of a tribal employee and coverage of family members terminates at midnight of the earliest of the dates described at § 890.304(a)(1)(vi) through (viii). The tribal employee and covered family members are entitled to a 31-day temporary extension of coverage without premium contribution and may convert to an individual policy as described at § 890.401.

(2) Enrollment is reinstated on the date the tribal employee is restored to duty in an eligible position with the tribal employer upon return from Uniformed Service, pursuant to applicable law, provided that the tribal employer continues to purchase FEHB for its tribal employees in the affected tribal employee's billing unit on that date.

### § 890.1413 Premiums and administrative fee.

(a) Premium contributions and withholdings described at §§ 890.501 and 890.502 must be paid by the tribal employer and the tribal employee, except that the term OPM as used in § 890.502(c) is deemed to be a reference to the paymaster, as appropriate, for purposes of this subpart. There is no Government contribution as that term is used in 5 U.S.C. 8906.

(b) *Contribution requirements.* (1) A tribal employer must contribute at least the monthly equivalent of the minimum Government contribution for a specific FEHB plan as described in 5 U.S.C. 8906;

(2) There is no cap on the percentage of premium that a tribal employer may contribute, as long as the contribution and withholding arrangement is not designed to encourage or discourage enrollment in any particular plan or plan option;

(3) A tribal employer may vary the contribution amount by type of FEHB enrollment (self only, self plus one, self and family), providing it is done in a uniform manner and meets the requirements described in §890.1413(b)(1) and (2); and

(4) A tribal employer may vary the contribution amount by billing unit, providing each billing unit meets the requirements described in §890.1413(b)(1) through (3).

(c) A tribal employer may, but is not required to, prorate the tribal employer and tribal employee share of premium attributable to enrollment of its part-time tribal employees working between 16 and 32 hours per week by prorating shares in proportion to the percentage of time that a tribal employee in a comparable full time position is regularly scheduled to work.

(d) Tribal employee and tribal employer contributions to premiums under this subpart will be aggregated by the tribal employer. The tribal employee and tribal employer contributions must be available for receipt by the paymaster on an agreed upon date. The paymaster will receive the premium contributions together with the fee described at paragraph (e) of this section and will deposit only the premium payment into the Employees Health Benefits Fund described in 5 U.S.C. 8909.

(e) A fee determined annually by OPM will be charged in addition to premium for each enrollment of a tribal employee. The fee may be used for other purposes as determined by OPM. The fee must be paid entirely by the tribal employer as part of the payment to purchase FEHB for tribal employees, and must be available for collection by the paymaster, together with the aggregate tribal employee and tribal employer contributions.

### §890.1414 Responsibilities of the tribal employer.

(a) The tribal employer pays premiums for tribal employees enrolled under this subpart pursuant to §§890.1403 and 890.1413.

(b) The tribal employer must determine the eligibility of individuals who attempt to enroll for coverage under this subpart and enroll those it finds eligible.

(c) The tribal employer must determine whether eligible tribal employees have eligible family member(s) and allow coverage under a self plus one or self and family enrollment as described in §890.302 for those it finds eligible.

(d) The tribal employer must establish or identify an independent dispute resolution panel for reconsideration of enrollment and eligibility decisions as described in §890.1415.

(e) The tribal employer has the following notification responsibilities. The tribal employer must—

(1) Notify OPM and tribal employees in writing of intent to revoke election to purchase FEHB at least 60 days before such revocation described at §890.1404(d);

(2) Promptly notify tribal employees and OPM if there is a change in the tribal employer's entitlement to purchase FEHB described at §890.1410(d);

(3) Promptly notify affected tribal employees of termination of enrollment due to non-payment, the 31-day temporary extension of coverage and its ending date described at §890.1410(f)(2) through (3); and

(4) Promptly notify affected tribal employees of termination of enrollment due to non-payment described at §890.1410(f)(4).

### §890.1415 Reconsideration of enrollment and eligibility decisions and appeal rights.

(a) The tribal employer shall establish or identify an independent dispute resolution panel to adjudicate appeals of determinations made by a tribal employer denying an individual's status as a tribal employee eligible to enroll in FEHB or denying a change in the type of enrollment (*i.e.:* to or from self

only coverage) under this subpart. Such panel shall be authorized to enforce enrollment and eligibility decisions. The tribal employer shall notify affected individuals of this panel and its functions.

(b) Under procedures set forth by the tribal employer, an individual may file a written request to the independent dispute resolution panel to reconsider an initial decision of the tribal employer under this subpart. A reconsideration decision made by the panel must be issued to the individual in writing and must fully state the findings and reasons for the findings. The panel may consider information from the tribal employer, the individual, or another source. The panel must retain a file of its documentation until December 31 of the 3rd year after the year in which the decision was made, and must provide the file to OPM upon request.

(c) If the panel determines that the individual is ineligible to enroll in FEHB as a tribal employee or to change enrollment, the individual may request that OPM reconsider the denial. Such a request must be made in writing and any decision by OPM will be binding on the tribal employer.

(d) OPM may request a panel decision file during the retention period described at paragraph (b) of this section. Panel decisions remain subject to final OPM authority to correct errors, as set forth in §890.1406.

### §890.1416 Filing claims for payment or service and court review.

(a) Tribal employees may file claims for payment or service as described at §890.105.

(b) Tribal employees may invoke the provisions for court review described at §890.107(b) through (d).

### §890.1417 No continuation of FEHB enrollment into retirement from employment with a tribal employer.

(a) An FEHB enrollment cannot be continued into retirement from employment with a tribal employer.

(b) A Federal annuitant may continue FEHB enrollment into retirement from Federal service if the requirements of 5 U.S.C. 8905(b) for carrying FEHB coverage into retirement are satisfied through enrollment, or coverage as a family member, either through a Federal employing office or a tribal employer, or any combination thereof.

(c) A Federal annuitant who is employed after retirement by a tribal employer in an FEHB eligible position may participate in FEHB through the tribal employer. In such a case, the Federal annuitant's retirement system will transfer the FEHB enrollment to the tribal employer, in a similar manner as for a Federal annuitant who is employed by a Federal agency after retirement.

(d) A tribal employee who becomes a survivor annuitant as described in §890.303(d)(2) is entitled to reinstatement of health benefits coverage as a Federal employee would under the same circumstances.

### §890.1418 No continuation of FEHB enrollment in compensationer status past 365 days.

A tribal employee who is not also a Federal employee who becomes eligible for one of the Department of Labor's disability compensation programs may not continue FEHB coverage in leave without pay status past 365 days.

# PART 891—RETIRED FEDERAL EMPLOYEES HEALTH BENEFITS

## Subpart A—Administration and General Provisions

Sec.



## Subpart B—Election and Change of Election



## Subpart C—Suspension and Termination



## Subpart D—Contributions and Withholdings